July, 1955

Canadian Hospital

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Canadian Hospital Association

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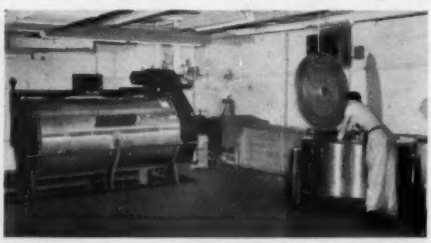

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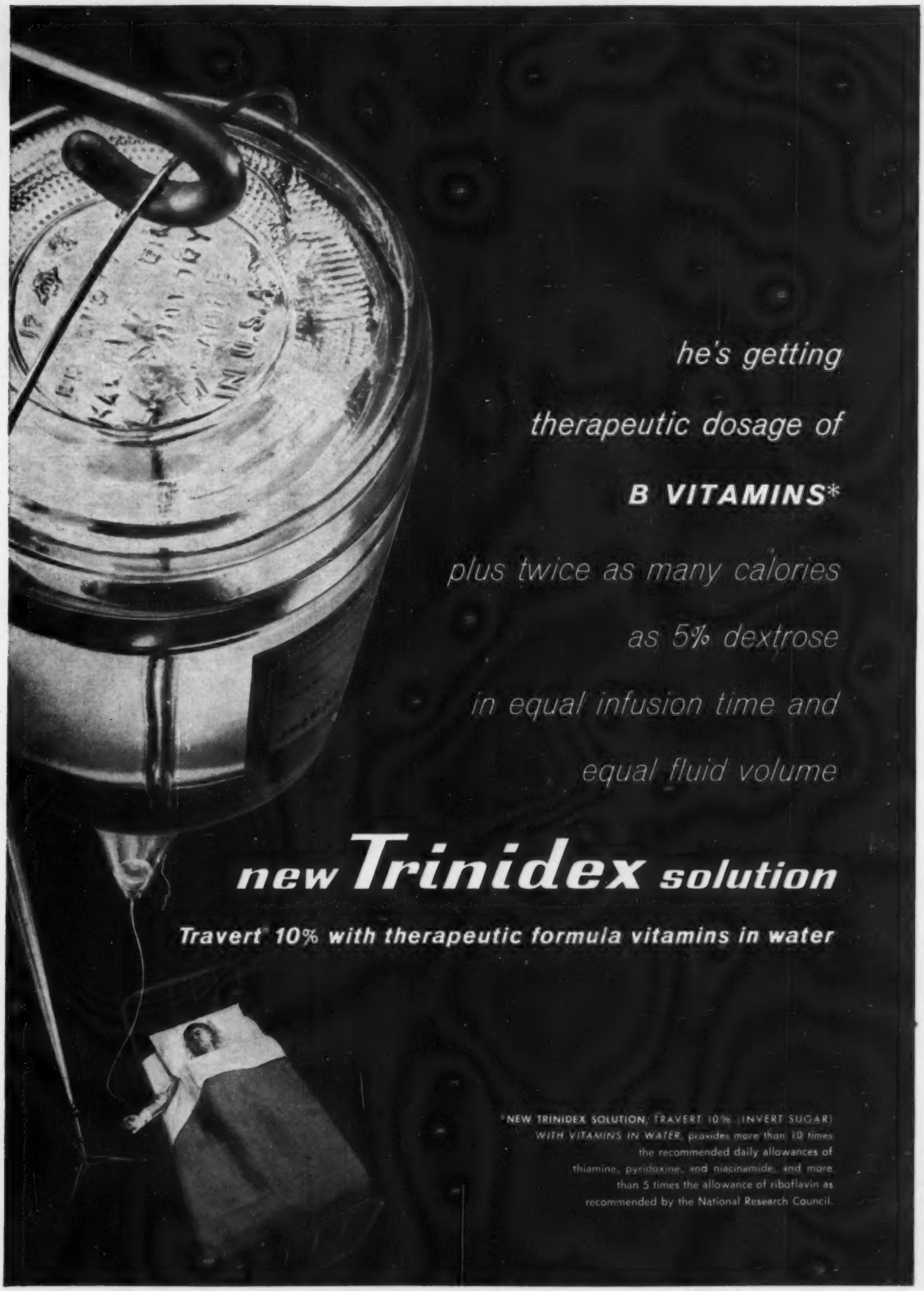
Contents

Vol. 32 **JULY, 1955** No. 7

(For Subscription Rates, see page 20)



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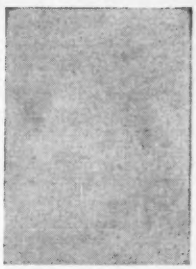

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Notes About People

About the president of the Canadian Hospital Association

(This is the first of a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57—Edit.)

Dr. J. Gilbert Turner, president of the Canadian Hospital Association, is the executive director of the Royal Victoria Hospital in Montreal, P.Q., a position he has held since 1947.

A native of New Brunswick, Dr. Turner was graduated in medicine from McGill University in Montreal and practised medicine in Fredericton, N.B., from 1934 until 1940. For the

J. Gilbert Turner, M.D.

next five years, he was in the Royal Canadian Air Force, holding the post of Principal Medical Officer of Eastern Air Command. Upon discharge, he held the rank of Wing Commander. Dr. Turner then took two years of post-graduate study in hospital administration at St. Luke's Hospital in New York, N.Y., and Columbia University, receiving his master's degree from the latter.

Always an active participant in hospital affairs, Dr. Turner has been a director of the Canadian Hospital Association since 1951. He is first vice-president of the Montreal Hospital Council and a member of the executive of the Quebec Hospital Service Association. He is a trustee of the American Hospital Association and a Fellow of the American College of Hospital Administrators. A speaker with authority, as well as oratory, Dr. Turner is much in demand at hospital meetings in various provinces. He is also a lecturer in the faculty of medicine at McGill University and a guest lecturer in hospital administration at the University of Toronto. His writings, too, have appeared in several publications, including *The Canadian Hospital*. All these abilities, together with a keen interest in the hospital field and hospital people, well befit Dr. Turner for his duties as president of our national association.

* * * *

University of Toronto Announces Research Program in Hospital Administration

The faculty of the Department of Hospital Administration, School of Hygiene, University of Toronto, has announced the commencement of a two-year program of research to be known as Practical Studies in Education for Hospital Administration. The project will be directed by Harold G. Dillon, who has been appointed to the faculty as research fellow. Since the summer of 1952, Mr. Dillon has been on the staff of the Canadian Hospital Association as an administrative assistant, for the committee on education. In this capacity, he has been closely associated with the development of the C.H.A. extension course in hospital organization and management.

Born in Collingwood, Ont., Mr. Dillon served with the Royal Canadian Air Force, from 1941 to 1946. In 1950, he was graduated from the University of Western Ontario, in London, with the degree of Bachelor of Arts in business administration. After graduation, he enrolled in the course in hospital administration at the University of Toronto and served his administrative residency at the Victoria Hospital in London, Ont.

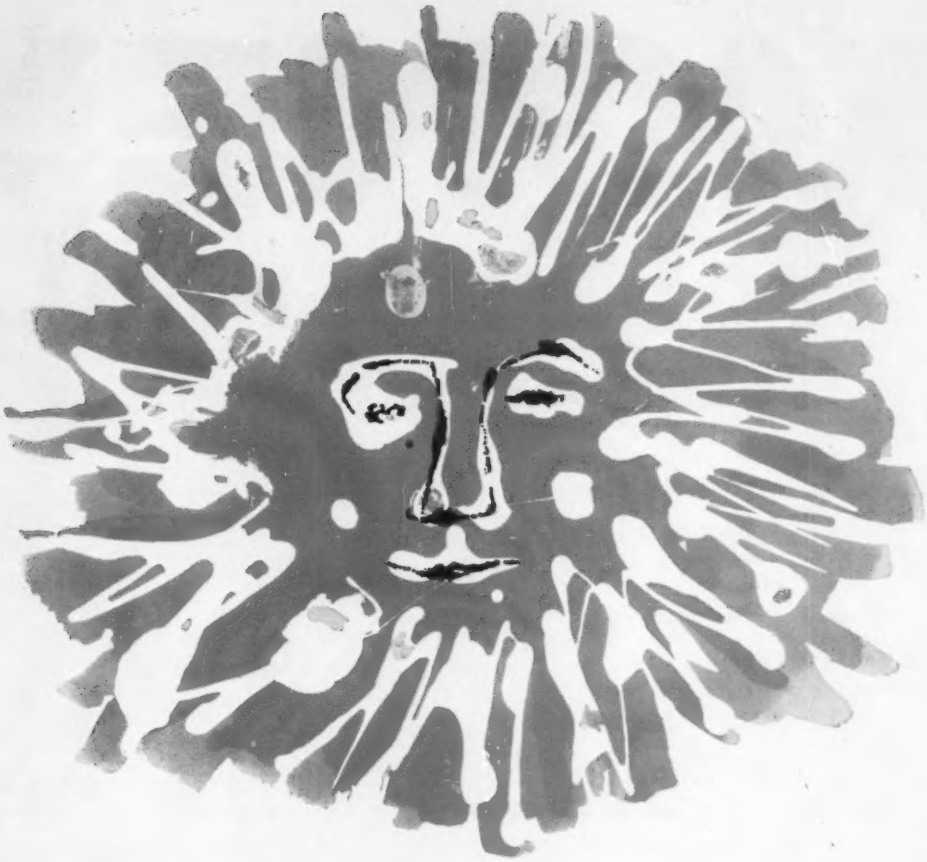
The new program which Mr. Dillon will direct is consistent with the Department of Hospital Administration's policy of keeping its curriculum under constant review, with the object of utilizing the most effective educational methods. The practical studies are an adaptation of what is currently known as the case-study method of teaching. As such, they consist of written, factual accounts built around actual situations. A selected series of these studies is generally presented over a relatively short period of time to the study group concerned, who, in turn, are required to analyze and evaluate the principles and practices outlined or inferred in each study. Under the guidance of a qualified discussion leader, the method introduces a considerable degree of practicality into an academic session. In addition, consideration will also be given to the possibility of using study materials outside the classroom.

The project, now in its initial stages is concerned with the compilation of

Harold G. Dillon

suitable source material from which to make selections for a final series. A great deal of preparation, revision, and evaluation will then follow. It is intended that as many facets as possible be reflected in the completed material, including relationships with health agencies and organizations outside the hospital itself. Principles of organization and management are to be stressed along with personnel administration and human relations. In total, these are seen as reflecting, to some extent at least, the "daily life" of the hospital administrator. The new program is receiving the support of the W. K. Kellogg Foundation of Battle Creek, Mich.

(Concluded on page 16)



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Notes About People

(Concluded from page 12)

Fred G. Hubbard Appointed to Denver, Colorado

Fred G. Hubbard, formerly an assistant director at the Vancouver General Hospital in Vancouver, B.C., has assumed the position of director of administration services, at the Denver Department of Hospital and Health Services, Denver, Colorado.

A graduate of the University of Minnesota's degree course in hospital administration, Mr. Hubbard joined the staff of the Vancouver General in 1949 as an administrative resident. In June, 1950, he was appointed an administrative assistant and acting purchasing agent for the hospital. He became an assistant director in 1952.

* * * *

Doctors Honoured by University of Toronto

Three Canadian and three British doctors were presented with honorary doctor of laws degrees at the medical convocation of the University of Toronto in June. The Canadians were: Dr. T. C. Routley of Toronto, Ont., president of the Canadian and British medical associations; Dr. George F. Strong of Vancouver, B.C., immediate past president of the Canadian Medical Association; and Dr. Wilfred Warner of Ottawa, director general, Department of Veterans' Affairs Treatment Services. The Britishers were: Sir John William McNee, immediate past president of the British Medical Association and physician in Scotland to Her Majesty Queen Elizabeth; Dr. Edward Gregg, adviser to Britain's National Health Service; and Dr. Stanley Graham, British paediatrician.

* * * *

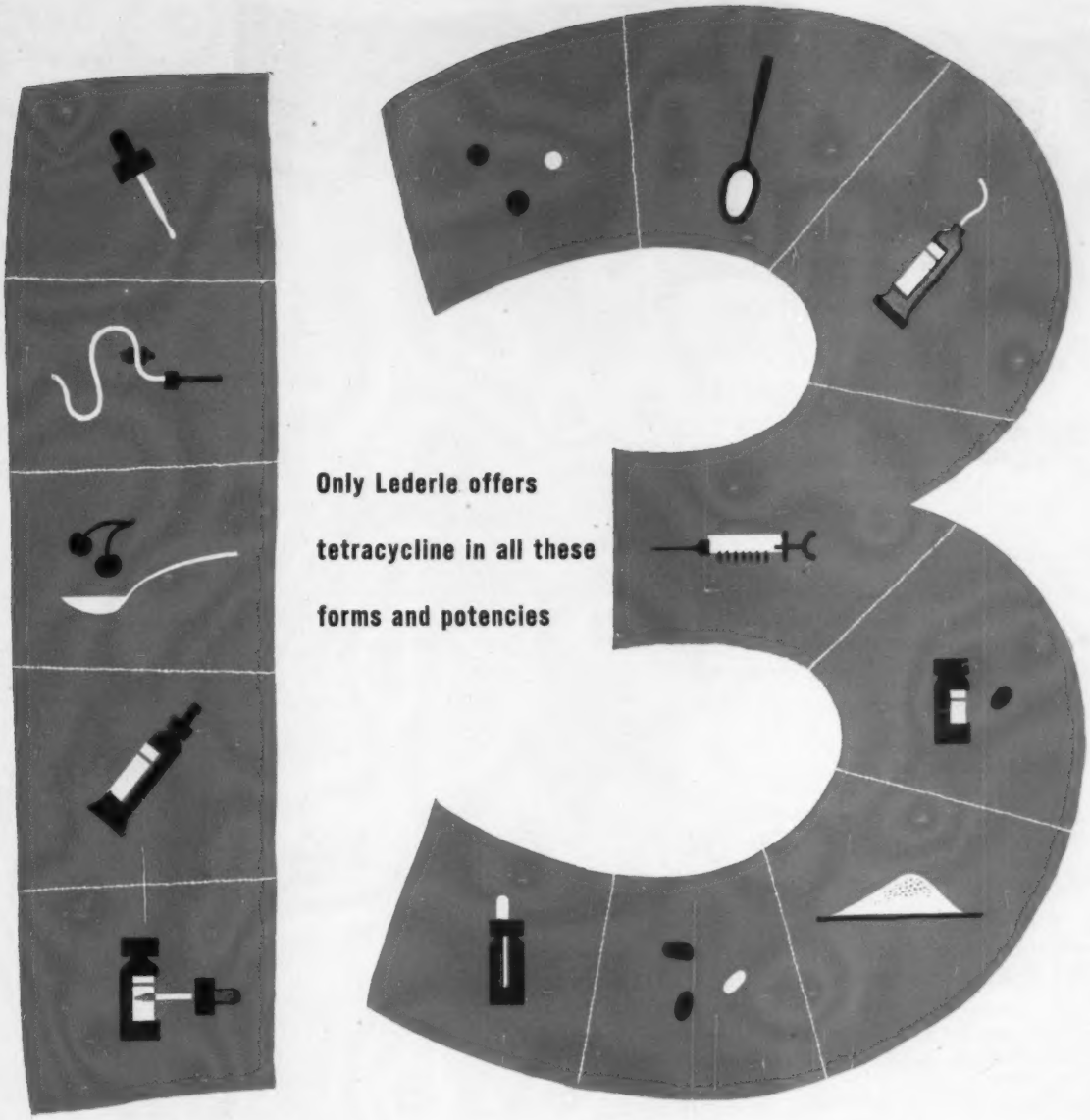
Charles Vézina, M.D.

Charles Vézina, M.D., who had been chief surgeon at the Hôtel-Dieu de Québec from 1932 until last January, died in Quebec last April at the age of 67. From 1940 to 1954, Dr. Vézina had been dean of the faculty of medicine at Laval University. While at the Hôtel-Dieu, he founded a neurological and orthopaedic clinic and at Laval he established departments of research and experimental medicine.

During his life-time, Dr. Vézina earned many honours including: Commander of the British Empire, Knight of the Legion of Honour, Commander of the Order of St. Gregory the Great, and officer of the Order of St. Jean de Dieu. He had also been president of l'Association des Médecins de Langue Français du Canada and of the Royal College of Physicians and Surgeons of Canada.

● Colonel E. A. Baker, managing director of the Canadian National Institute for the Blind in Toronto, Ont., has received the Leslie Dana Award for outstanding service in prevention of blindness. The award is given jointly by the St. Louis Society for the Blind, the National Society for the Prevention of Blindness and the Association for Research in Ophthalmology. Colonel Baker is the first Canadian to receive the award which was presented to him at St. Louis, Mo.

● H. J. Peddy has resigned as secretary-treasurer of the Brooks Municipal Hospital in Brooks, Alta. His successor is James Robertson, formerly secretary-treasurer of Three Hills Municipal Hospital in Three Hills, Alta.



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Dr. Michael Lenczner, of the University of Toronto, is directing the service. Some 100 women enrolled in a special training course at the university in preparation for their duties in the hospital. They will help to translate case histories, assist doctors and medical personnel in the wards, and stand by in the emergency and admitting departments. Each volunteer will be on duty once a week. Interpreters for the more common languages, such as German, Italian, and Ukranian, will be on hand on a 24-hour basis while interpreters for Japanese, Danish, and other languages will be on call.

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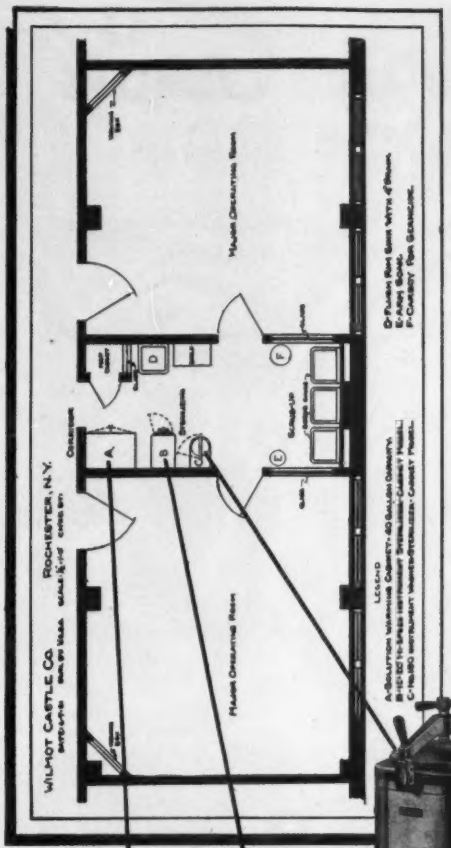

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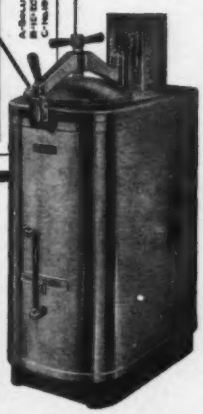

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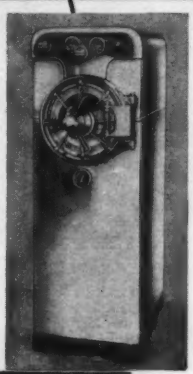

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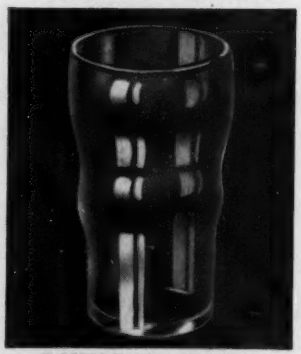

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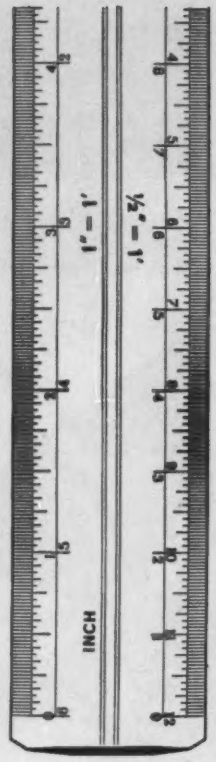

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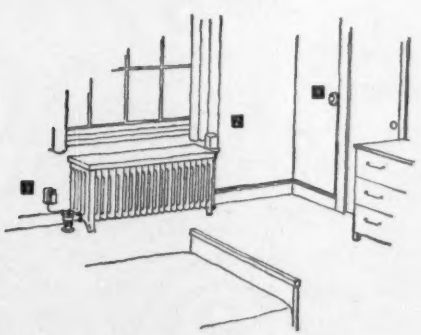

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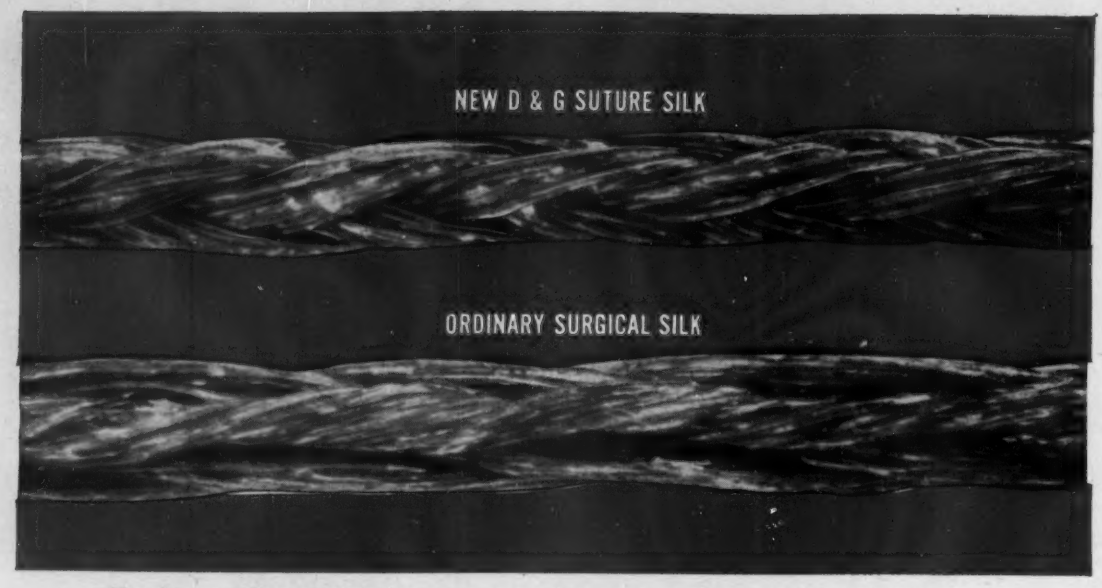

▲ **There's more silk per suture.** Photomicrography shows greater strength and uniformity of new D & G suture silk as compared to ordinary silk. See how the x's indicate the high braid count.

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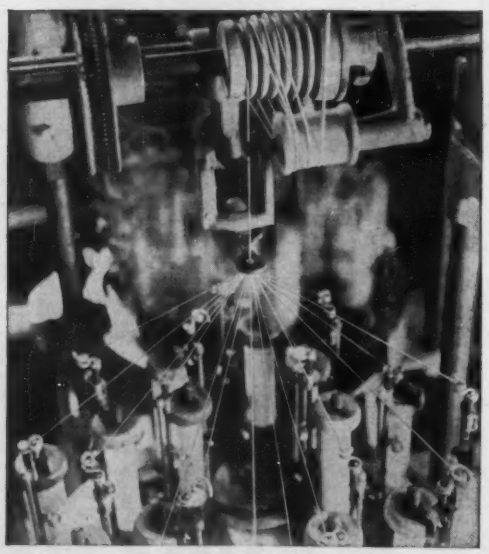

▲ **For greatest strength of silk** in a given diameter, D & G especially redesigned this machine. To braid so many filaments so tightly into a single 10-foot strand of 4-0 silk takes one hour. Rigid control of humidity and temperature during braiding keeps silk uniformly strong and pliable.

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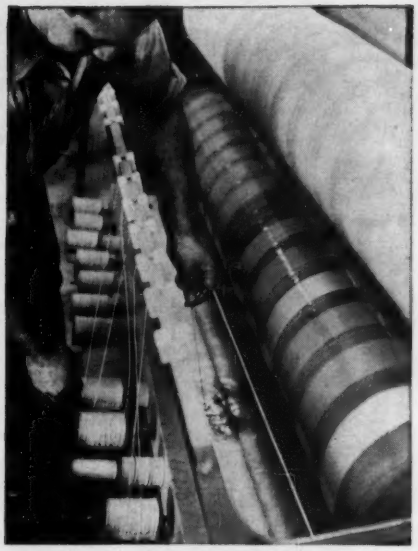

▲ **Not only uniform tensile strength,** but also uniform texture and diameter of strands result when D & G stretches wet silk from 5% to 20%, depending on size. This precise stretching aligns the molecules for utmost strength.

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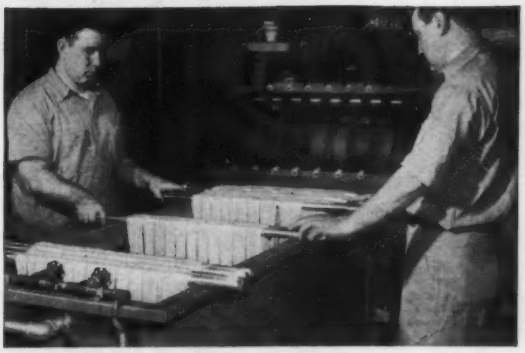

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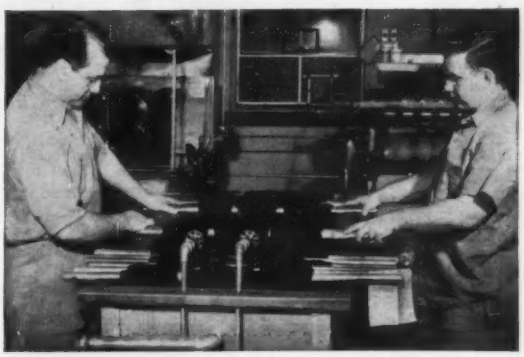

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Concerning Trends in Construction

IN RECENT YEARS Canadian hospitals have been expanding and renovating rapidly in order to meet the need for more beds and the growing demand for ancillary services. In addition, many completely new plants have been built and equipped, either to replace obsolete structures or to serve areas which previously had no hospital. These range from large metropolitan hospitals down to rural community health centres and, across the country, there are many still in the planning stage.

In *The Canadian Hospital* we have featured construction projects from time to time, including in such articles exterior and interior views, as well as floor plans where possible. In this issue we publish a group of three articles pertaining to certain aspects of hospital construction. One article discusses current trends in hospital architecture, particularly as revealed in Sweden; a second deals with factors in construction peculiar to Canada; and a third with types of paint and their uses. Besides these, several pages are devoted to exterior views of representative hospitals which have been constructed in Canada in the past few years.

In construction, the question of future plant maintenance is a vital one. One hospital engineer has stated that maintenance begins the day the contractor leaves. Certainly a planned program of maintenance is necessary; otherwise the cost will become very heavy in the long run. One of the factors in maintenance which requires constant attention is paintwork. The superintendent and the hospital engineer must utilize the type of paint which is especially produced for use on any given surface. Whether it be in the operating room, the corridor, a utility room, or a patient's room, hospital people ponder frequently the merits of various types of paint—to say nothing of colour schemes. For these reasons we welcome the opportunity of including an article on paint, grouped with those on construction, in this issue.

Every hospital board and every hospital administrator has faced the problem of planning the new space required but, in addition, there often arises the problem of adapting the new to fit in with the old, a feat which is not always easy to accomplish. Again there is constantly present the question of final cost and the challenge of producing a unit which is not only beautiful, functional, and up-to-date, but also suitable to Canadian conditions and climate. With all these thoughts in view, we trust that the articles published here will prove of value to hospital people.

Progress in Accreditation

MANY OF OUR readers found Dr. E. Kirk Lyon's address on accreditation, presented to the 13th biennial meeting of the Canadian Hospital Association and published in the June issue of *The Canadian Hospital*, of particular interest. Dr. Lyon has a very extensive knowledge of hospital accreditation as it has developed in Canada and the United States and the statistics he presented were most illuminating. Hospital people throughout Canada will be pleased with Dr. Lyon's assessment of the present position with respect to accreditation and he is undoubtedly qualified to speak authoritatively on this subject. Dr. Lyon has stated:

"The Joint Commission on Accreditation of Hospitals has now been in operation for approximately three and one-half years. It has long since passed the stage of organization and is now, in my opinion, a smoothly functioning body representing the best thinking in the field of hospital and medical services on this continent. I am of the firm opinion that this organization is doing a monumental work in improving the hospital and medical care for the people of the United States and Canada. It has been very encouraging to those of us who have access to the confidential reports of the Commission to note the improvements shown in many of the hospitals after a visit by a surveyor of the Joint Commission. The objective

of the Joint Commission on Accreditation of Hospitals is not one of police action but one of education and all the field surveyors are especially trained and instructed not only to make a survey of the hospital, but to render every assistance possible to the medical staffs, the hospital superintendents and to boards of governors when requested."

It is quite evident from the statistics given in Dr. Lyon's address that as yet many of our Canadian hospitals have not taken advantage of the benefits derived from a survey by the Joint Commission on Hospital Accreditation. There are in Canada some 853 general hospitals of 25 beds or more. Of the hospitals surveyed over 80 per cent have received full or provisional approval. This in itself is all very good. The real point, however, is that many hospitals have never applied for a survey and as a result only some 33 per cent of the 853 are fully or provisionally approved. This figure is given for Canadian hospitals as a whole and on a provincial basis the figures vary considerably. Thus, New Brunswick with 58.8 per cent and Prince Edward Island with 57.1 per cent head the list. It would appear that much remains to be done and more publicity is needed to interest all those hospitals of 25 beds and more who have not as yet applied for a survey. This interest in the over-all benefits to be derived from the accreditation program must be shared by hospital boards, medical staff, and administration. It is to be hoped that when the figures for 1955 are released they will show a marked improvement over the previous year.

Co-operation is Imperative

TO BE ABLE to appreciate the other fellow's point of view is a great asset in hospital administration. Frequently, as I attend hospital meetings, I am reminded of this by the various questions which superintendents ask, as they seek solutions to their problems. Dr. L. W. Shaw, deputy minister of education for the province of Prince Edward Island, when addressing the dinner session of the Maritime Hospital Association recently, reminded his audience that hospitals are people. Most of the problems which hospital staffs face revolve around people and their relations one with another.

Hospital administration, to be successful, involves team work between people who have different backgrounds of training and have different outlooks and viewpoints. Even though we are all trying to do what is best for the patient, we are prone to approach our daily problems primarily from the point of view of our own training, whether this be medical, nursing, business, or technical. The point to be remembered is that all can contribute something of value to the work as a whole and that this contribution can be greatly enhanced if we use the team approach in trying to solve our daily problems.

Perhaps nowhere is this better illustrated than in the case of the nurse administrator and a business or office manager. Each may approach the very same problem in an entirely different way. In those institutions where the nurse is the administrator and a business manager is also employed, friction frequently develops simply because the two do not sit down together and work out the problem jointly. One has a background of professional service, the other business training. The talents of each are essential to the operations of all hospitals and friendly co-operation is imperative.

To Lift the Spirit

SPRING and Fall are traditional times for the holding of meetings and conventions. The Spring of 1955 has been no exception and there have been several meetings at national, provincial, and regional levels. In the June and July issues of *The Canadian Hospital* we have reported these meetings and published certain addresses which were presented. In addition to hospital business meetings as such, there have been others of a purely educational nature. An account of this year's sessions of our oldest established institute, the Western Canada Institute for Hospital Administrators and Trustees is given on page 18 of this issue; and an outline of the Maritime Hospital Association meeting appears on page 53.

One of the outstanding values of such gatherings to hospital people is the opportunity afforded them of meeting many people engaged in the same work, of exchanging views and making contacts. No one attends a meeting without learning something and, at times, the major value may be in ascertaining that the other fellow has problems also and that something which you may have considered as peculiar to your own institution has to be faced and solved by your associates elsewhere. Being aware of what is going on in the field is important to every hospital person. Hospital journals can do much to keep trustees and administrators informed of trends. However, personal attendance at hospital meetings, in addition to being educational, does much to lift the spirit and send us all back to our routine rejuvenated.

De la Necessité d'un Cours d'Extension en Comptabilité Hospitalière

A LA SUITE des réunions qui ont précédé et suivi la 13 ième assemblée biennale de l'Association des Hôpitaux du Canada tenue à Ottawa en mai dernier, le Bureau des Gouverneurs de cette Association a pris deux importantes décisions: l'une touchant la publication du manuel de comptabilité hospitalière, l'autre l'organisation d'un cours d'extension en comptabilité hospitalière.

Le manuel canadien de comptabilité hospitalière fut publié en 1952 par l'Association des Hôpitaux du Canada et payé à même les fonds fédéraux prévus par le Programme National de Santé et versés à la province d'Ontario. Les éditions française et anglaise de ce manuel ont couté environ $24,000. Chaque hôpital du Canada a reçu gratuitement une copie de ce manuel et des copies additionelles furent expédiées sans frais aux grands hôpitaux et à leurs auditeurs aussi qu'à certains départements gouvernementaux. Ce manuel de comptabilité hospitalière a rendu d'innombrables services aux hôpitaux en leur permettant d'établir un système standard de comptabilité. La première édition du manuel est épuisée et le Bureau des Gouverneurs en a autorisé une seconde. Cette nouvelle

(Suite à la page 90)

Constructing hospitals to suit

Canada's Economic and Climatic Conditions

James Govan, F.R.A.I.C.,
Toronto, Ont.

IF IT BE assumed that Canada's population will increase at about the same rate as it has during the past 50 years and that a demand for six hospital beds per 1,000 people will have to be met, this means 6,000 beds per each additional million people. To attain this goal, the clamour for provincial and federal governmental assistance with capital grants is likely to be even higher than it is at present. These government grants do not total one-sixth of the capital cost per bed for buildings, equipment, furniture and furnishings, roads, walks, and grounds, housing of nurses and staff, and technical services engaged for the work of financing, planning and supervising construction; yet none of these items can be ignored in preparing comparative cost data on a "per-bed" basis.

When the annual deficits of most of the existing urban hospitals in Canada are studied—deficits resulting from the care of indigent patients—it is obvious that trends which indicate possible increases in hospital deficits need careful examination.

Heat, Light and Power

One of the controllable factors in determining annual operation cost per bed is the cost of heat, light, and power. The following is quoted from a paper received a year ago from C. F. Neergaard, hospital consultant in New York, N.Y.:

"The present spread in hospital power, light, and heat costs is fantastic. Greenman, MacNicol and Co. have assembled the 1952 operating figures for 53 hospitals for which they are auditors. In the group of 18 large institutions, ranging from 281 to 635 beds, the average annual cost per bed for power, light, and heat was $289, but with a spread of from $172 to $463. These 18 hospitals had a combined operating deficit of $4,687,020, *excluding depreciation.* From our own data, several hospitals with new additions which were fully insulated, with new heating plants and only the necessary exhaust ventilation, spent from $74 to $97 a bed per year for the entire plant, new and old.

"An entirely new hospital, properly designed and insulated, with a mechanical plant which incorporates the most effective type of heating and simple exhaust ventilation should not have to spend over $70 per bed per year. In a hospital so designed perhaps a simplified cooling system with conservative ventilation might be an economic possibility. To develop what the hospital might afford will call for the closest co-operation, imagination, and vision on the part of the architect, the consulting engineer who designs the plant, and the air conditioning manufacturer who furnishes the equipment."

We have evidence in our own practice that the $70 per bed for heat, light and power to which Mr. Neergaard refers would, if anything, be a high figure, provided construction methods are used that will definitely reduce heat losses from outside and inside the building.

James Govan

As a definite example of what can be done to reduce heat and power costs, we replaced an old, much smaller but so-called well-built hospital with a new well-insulated, double-glazed institution. For the new 6,000,000 cubic feet institution the reduction in steam consumption for heating only, when compared with that for the original group of buildings which were vacated, has been 52,000,000 pounds of steam, or approximately $46,888 per year. This represents the interest on an endowment fund of $1,872,000 at 2½ per cent interest.

On the basis of a reduction of $25,000 per bed per annum for heat, light and power—which we have proved in our work to be a very low figure—that represents the interest on $1,000 per bed at 2½ per cent or, for the 6,000 beds per million of added population, the interest on an endowment fund of $6,000,000. With these factors in mind, should the proponents of institution schemes be asked to show whether they propose to waste the equivalent of $1,000 per bed in undesirable and unnecessary capital expenditure?

Unfortunately, the trend towards copying architectural styles and construction methods which are unsuited to Canadian climatic conditions, indicates a likelihood of even larger annual deficits. Not only should attention be concentrated on this heat waste problem but the factor of patients giving up body heat to cold glass surfaces also needs careful study. It is impossible for a patient near a large cold glass surface to be as comfortable as a patient lying farther away from the glass except under conditions where radiant heat from the ceiling or floor is provided to offset the loss of body heat to the glass.

From the foregoing, it should not be assumed that the exterior walls of

a modern hospital must be built of masonry or brick with openings limited in area. In fact, the need for thick, heavy concrete or masonry walls in the exterior of a modern hospital in Canada should be seriously questioned, because of problems of moisture penetration, freezing and thawing with resulting deterioration of the structure and evidence of condensation in the thickness of the walls.

Providing for Alterations

Changes in the use of floor space which occur so frequently in hospitals provide increasing evidence that the interior areas should be so constructed as to permit the removal of partitions extending from the exterior walls to corridors to facilitate rearrangement or relocation of departments. This necessitates concentrating the risers for mechanical services nearer to the corridor walls. Under such an arrangement the division of exterior walls between structural columns into multiple interchangeable glass and insulated panel units is fundamentally sound. What should be questioned is the filling of more of these interchangeable units with glass than is necessary or desirable for health or economic reasons.

These thoughts prompt consideration of the question as to how permanent hospital construction should be. If it can be assumed that hospital buildings should be replaced at not more than 50-year intervals, what effect should that have on the selection of materials and methods of construction? Will the development of the helicopter result in the establishment of some hospitals in larger and more open sites and thus facilitate planning for future expansion of wings without necessitating the entire removal of parts and disruption of services?

Such a structure could be constructed of prefabricated units bolted together for quieter erection and also quieter changing when necessary. Our experience with bolting the steel framework of the high pavilion in the centre of the Toronto Western Hospital group, as far back as 1934, proved that the noise generally associated with constructing additions to existing buildings can be eliminated to such an extent that patients in adjacent wings were not disturbed to any serious extent.

Similarly, we proved that the exhaust from bulldozers and construction equipment of that nature could be muffled in fairly simple fashion. What is required is a realization on the part of contractors that the disturbances associated with their work can be very greatly reduced at relatively insignificant increase in construction costs.

Welding of steel structures can be used to lessen the noise nuisance but, for the purpose of facilitating later changes in hospital development which are almost inevitable, the use of bolting is much more practical and it can be done in such a way as to meet the requirements of building codes.

Air-conditioning

Apart altogether from the high cost of installing, operating, and maintaining air-conditioning in hospitals, there are other factors, we have noted in our studies and experiments which have a very definite bearing on patients' welfare.

Human comfort can be controlled by regulating the amount of heat given off from the body by radiation to surrounding cool surfaces or by radiating heat to the body from surrounding warm surfaces. It is, therefore, possible and quite practical to regulate conditions for individuals without adversely affecting the comfort of other people whose requirements regarding body heat loss may be quite different.

As a result of a careful study of conditions in four cubicles in a closed room in which the cubicles had walls carried from floor to ceiling and six ultra-violet lamps at the entrance opening into each cubicle, the following results were noted. Harmless types of bacteria were released in one of the cubicles and were collected in another cubicle in the opposite corner of the room. With the air in the room changed mechanically from once up to three times per hour, the bacterial counts in the collecting cubicle were quite satisfactory for practical purposes; but with more rapid air change in the room than three times per hour, neither the ultra-violet radiation from six lamps at the releasing cubicle nor six at the collecting cubicle, plus filtration in the ventilating apparatus, succeeded in stopping the spread of the bacteria from one cubicle to the other right across the diagonal direction of the room where the experiments were made.

Inasmuch as few, if any, installations of air-conditioning apparatus are operated at as low as three air changes per hour in rooms to be heated or cooled, the results of these experiments indicate the problem created in a hospital where cross infection must be guarded against. In hospitals, the nursery, operating and delivery areas are the ones that give most trouble and for which there is the greatest demand for air conditioning.

Some years ago my partner, Mr. Ferguson, and I visited several of the latest and what were then considered to be the best operating rooms in New York hospitals. In each of them we noted metal plates which gave definite figures regarding the temperature, humidity, et cetera, which were to be maintained for the safety of the patients. Our examination and enquiries revealed the fact that in not one of these hospitals were the conditions, under which operations were performed, made to correspond with the instruction figures on the plates.

I am still forced to conclude that there has been no satisfactory answer to the points raised in my paper, "Comfort of Surgeons and Operating Room Personnel and/or Safety of Patients", presented at the American College of Surgeons, Great Lakes Sectional Meeting at Toronto, March 23rd, 1938, and published in the April 1938 issue of *The Canadian Hospital*.

An experiment conducted at our suggestion by one of our clients in an existing surgical department is probably significant for Canadian surgeons and hospital personnel if not for those south of the border. The fans used to exhaust the air from the old operating rooms 10 times per hour were run all night from the time the outdoor air had cooled off a bit and were shut off in the morning. During that time the temperature of the air at ceiling, floors, walls, equipment, furnishings, et cetera, in the operating rooms was lowered to about the average of the outdoor temperature during the fan-running night period. The result was that in the forenoon when the surgeons were operating under the hot lights, they were able to give up their body heat to the colder surfaces.

Inasmuch as most of the surgical work was over by the time the midday temperature outdoors would have

(Concluded on page 80)

Flowers and good furniture add to the attractive appearance of this patient's day room at the University of Uppsala Hospital, Uppsala, Sweden. Architects were G. Birch-Lindgren and R. Holmgren.

A Swedish architect looks at

Hospitals of Tomorrow

Gustaf Birch-Lindgren,
Stockholm, Sweden

DURING THE PAST few years, there has been a boom in hospital construction the world over and it seems to continue. What will be the trend during the next few years? Before trying to answer this question, it should be mentioned in this connection that my experiences are chiefly based on Swedish conditions* and that I speak chiefly of general hospitals as they are far in the majority.

With the increasing number of hospitals and with larger and larger hospitals, the economy of hospital construction and operation must be a more and more important factor in the general economy of a country. At the same time, the difficulty of obtaining a sufficient number of doctors and qualified nurses has been increasingly marked. I think these factors will long dominate the problem of planning, as the total cost of all salaries generally amounts to about 60 per cent of the total operational costs in a general hospital. Thus the problem is to obtain the most highly qualified personnel possible and to make use of their services in the best way possible. This is, of course, no new truth but it has been sharpened more and more with the years. How does it affect planning?

First of all, the stay of the patient in the hospital must be no longer than is absolutely necessary. This means that all the facilities must be there to help with his care from his very first day in hospital. For instance, he must not be kept waiting days for an x-ray examination, laboratory tests, et cetera, simply because these departments are inadequate to meet the demand for their services. In this respect, a hospital can be compared with a factory, *e.g.*, an automobile factory. The total number of cars produced depends on each sub-department delivering its parts with the same speed as the others, *i.e.*, the slowest sub-department determines the number of cars produced; in the case of hospitals the number of patients receiving prompt treatment.

Applied to hospital construction, this can also be expressed as follows. A hospital must be regarded as a whole, a unit. Careful consideration must be given to the dimensions of the different units in relation to each other. The calculation of their capacity must be based on statistical investigations. This seems easy, perhaps, but necessitates in fact considerable research work based on scientific methods. And this must be done with due attention to the progress of medical science.

Calculation in Planning

What really can be done by combining efficient planning and organization with medical development is demonstrated by an example—the average length of stay of patients in Orebro General Hospital in Sweden, a county hospital with about 500 beds. During the past 30 years, the average length of stay has been constantly reduced and is now less than half. In fact, if this had not been the case, the number of hospital beds would have had to be doubled, probably also the number of staff—both impossible because of economic and other reasons.

To the planner, this development means that he must base his planning on a more exact knowledge of the capacity of departments and units, expressed in figures giving relationships between areas and capacity, et cetera. The planning, in this way, is

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The author is an internationally known architect and has written "Modern Hospital Planning". See "The Canadian Hospital", March, 1953, p. 66 and Sept., 1952, p. 52.

**In Jan., 1955, a compulsory health insurance plan went into effect in Sweden.*

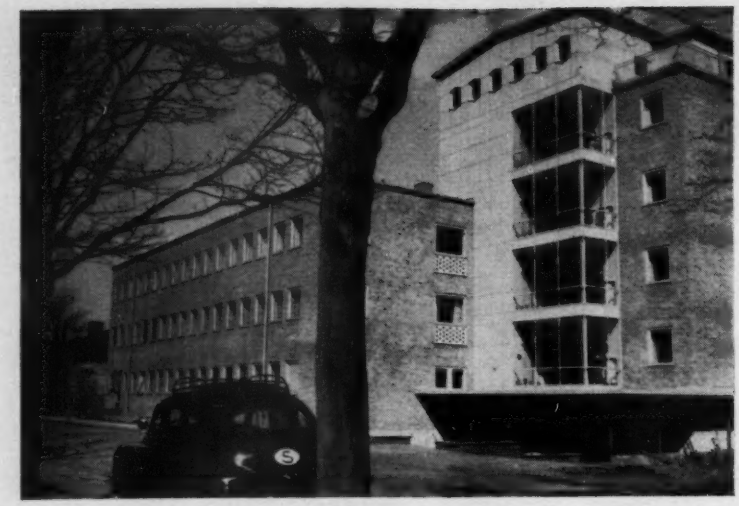
gradually becoming a problem of calculation, based on figures, with this scientific research becoming more and more a necessity. Such research work has already started in many places but much more has to be done.

The size of the hospital undoubtedly has a relation to its economy but our knowledge thereof is very diffuse. It is based chiefly on personal experience rather than exact knowledge. However, a widespread opinion is that, for many reasons, a hospital should not be larger than 600 to 800 beds.

The difficultly is that two hospitals are never exactly alike nor do exactly the same work, which makes comparison difficult. In Sweden, M. E. Molander has taken up this subject in *The Central Board on Hospital Planning and Equipment.* An example of Mr. Molander's studies is shown in Figure I which indicates that private rooms are the most frequented and thus should be placed in the middle of a ward. Figure II shows that the majority of transported items and errands are to the wards. Figure III illustrates the relation between floor space, kitchen staff, and portions served.

Of course, this is just a detail of the great problems and perhaps a beginning of the way to a deeper knowledge. I think, however, that if this kind of study were more generally undertaken, it would greatly facilitate future judgment in planning hospitals.

The architectural planning of the different departments in the hospital has been more or less standardized. The work done, for instance, by the late Marshall A. Shaffer, A.I.A., of the United States Public Health Service, has undoubtedly had an enormous influence in this respect. In Sweden, the same thing has occurred. For instance, the operating rooms of new Swedish hospitals of the same size are now almost identical. I think, therefore, that there will be very few changes in this aspect for some time. However, in the details, there will be a general trend towards new ways of facilitating the work performed. Besides this, the progress of medical science will be reflected in hospitals, necessitating constant modifications. These modifications can be brought about in many different ways—by practical details in planning, such as the double corridor system with the dark service rooms in the middle, and by better mechanical means such as



An example of modern hospital architecture in Sweden is the Malmoe General Hospital. This building contains the out-patient department, laboratories and pharmacy and was completed in 1954. Architects were G. Birch-Lindgren and S. Hornyanszky.

Figure I

No. Of Visits During One Day

No. of beds per room	1	2	6	8
No. of visits per bed	60.0	32.5	21.1	17.5

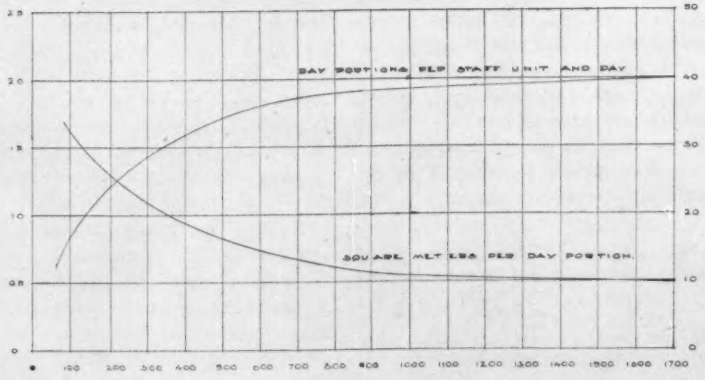
Figure II

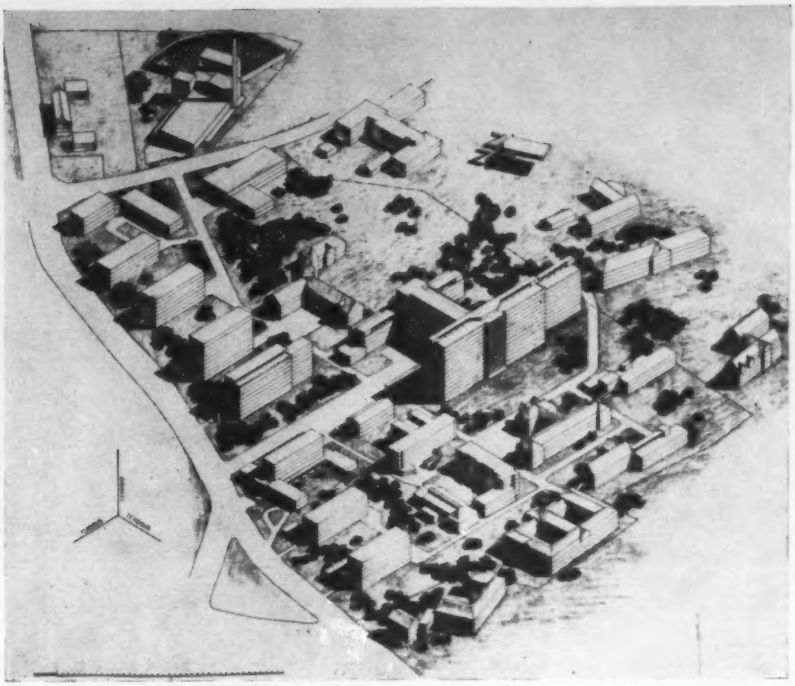
No. of Items Transported and Errands

	Kalmar		*Norrkoeping*	
	Average per day	per cent	Average per day	per cent
From wards to other departments	292	56.0	297	66.8
From other departments to wards	37	7.1	35	8.0
Between other departments mutually	192	36.9	112	25.2
Total	521	100.0	444	100.0

Figure III

Relations between Floor Space, Staff and Portions Served



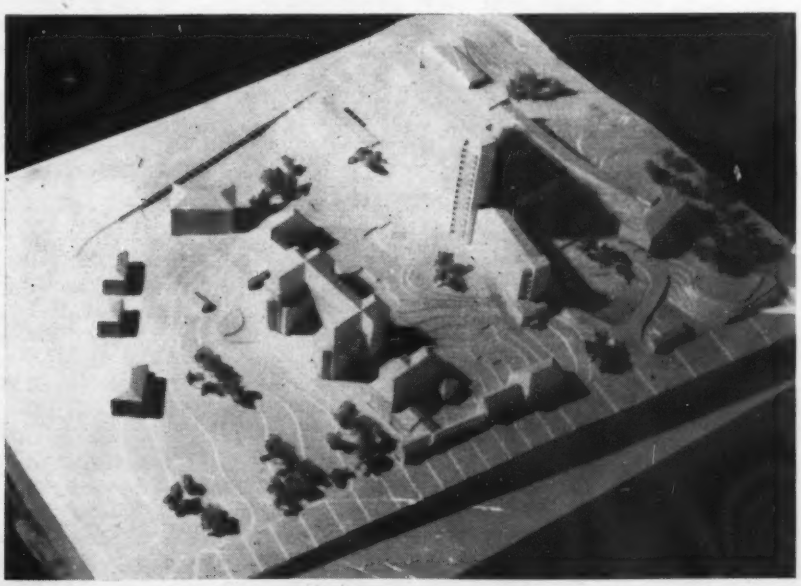


A new central block is being constructed in the middle of the large University Hospital of Lund which contains about 1800 beds. Around the central block are the clinics for the specialities already existing or planned. Architects are G. Birch-Lindgren and S. Hornyanszky.

signal systems, pneumatic tube systems, et cetera. There are unlimited and interesting possibilities.

The Block and Pavilion Systems

Another matter of importance is that of combining different departments into a complete unit, *i.e.*, a hospital. This can be done in many different ways. One thing that characterizes the modern hospital is the general increase in traffic which brings problems of a more and more dominating importance. Particularly do the central supply and central record services necessitate close connection with most other departments. The result is a concentrated plan, a block system. This is not the place to discuss block system *contra* pavilion system in general. The advantages and disadvantages are too well known to be repeated here.



The general hospital of Uddevalla has one new building, with the older buildings serving secondary purposes. The architects are G. Birch-Lindgren and E. Lohk.

This patients' room was decorated and equipped to the specifications of the author.

However, there are two special types which should be mentioned in this connection. They concern the small hospital and the very large one.

Undoubtedly a small hospital up to 200 beds can be built more cheaply by using one-storey pavilions of light construction (and why not prefabricated elements?) without staircases and elevators. Up to a certain size, this type of construction might not affect the operating costs, at least not the most important factor in them, the salaries. The difficulty is to know just when this occurs, *i.e.*, when a saving in building cost will be counterweighed by a higher operating cost. As the relation between building cost and operating cost is about one to four or five, and the former happens only once while the latter is a yearly one, it is also clear that a very small rise in the operating cost counterweighs a great saving in building cost.

In my opinion, it seems possible that from the point of view of economy, to adopt one of the latest developments in the building industry, *e.g.*, light prefabricated construction for a one-story building, might be a good solution. But where the limit is, it is not possible to state without a deeper knowledge of all the factors which are involved in hospital economy and without knowing the local conditions in every case. In addition, there comes the question of whether or not a natural growth of a hospital is possible with a pavilion system. Another solution of the problem, of course, is to erect simple one-storey buildings in the beginning and simply replace them with multi-storey blocks, when they have served their time.

Accommodating the Specialities

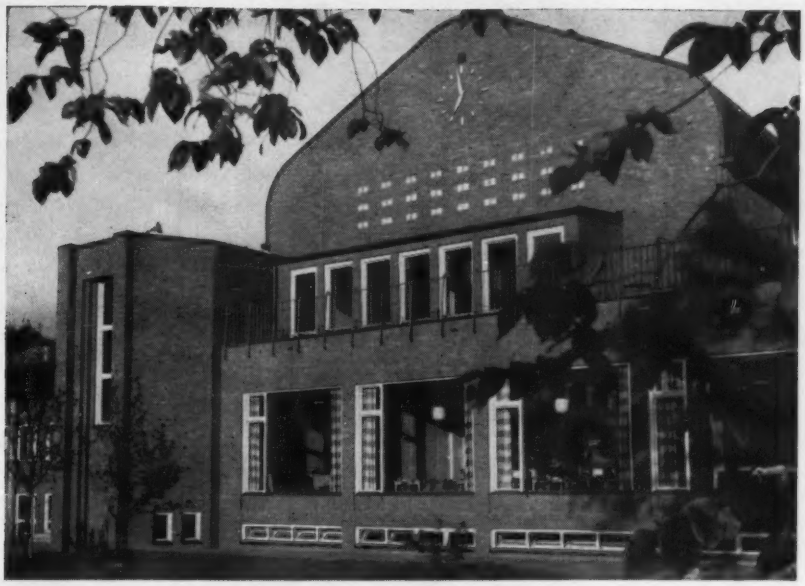
As for the medium-sized hospital of 600 to 800 beds, I think there is no doubt that the block system is the right solution. However, with more beds, comes a difficulty. Such a block will be difficult to handle, since it is in itself so big that the planning of different departments, the natural growth in the future, and the internal traffic will be affected. My experience tells me that in such a case the best solution is to create a central block for medicine and surgery and its specialities, with x-ray and laboratory departments, et cetera. Specialties such as ear, eye, nose and throat, gynaecology, and obstetrics, paediatrics, psychiatry, et cetera, can be placed in separate buildings around the central block without too many obstacles in operation. This pattern has been applied to the new university hospitals in Gothenburg and Lund (see illustration), now under construction, which when completed will have about 1,800 beds each.

Medical science is constantly developing with a corresponding demand for more space. This especially applies to the laboratories but also holds for other departments. At the same time, new specialties are incorporated in the hospital. Thus in Sweden, the psychiatric department has been found a necessity in every hospital of importance as a complement to other specialties of medicine.

Another specialty, which is becoming more and more important, is the geriatrics department. This is due to the fact that the average life span of people is constantly increasing. In Sweden, with its seven million people, it is estimated that in the year, 1965, one million people or 1/7th of the present population will reach the age of at least 65 years. What this will mean to the hospitals is clear and needs no further comment.

Always the Patient

It is, of course, most important to consider the patient in all aspects when speaking of the future of hospitals. From his point of view, the large hospital has more of an institutional flavour than the small one. From the medical point of view, the large hospital can often offer better possibilities for the patient's care. Whether small or large, everything must be done to give the patient the impression of being in a home and not of being just a number in an institution. Of course, it is chiefly a question of the spirit and atmosphere of the hospital but to create a back-



This interesting building houses the dining rooms and kitchen of the Sahlgrenska Hospital in Gothenburg. Architects were G. Birch-Lindgren and E. Lohk.

ground for this, the proper architectural details are essential. Colour, textiles, and furniture are important. In Switzerland, washable wall paper has been used instead of paint and has been found to be economical as well as adding to the home-like atmosphere. Many other new and modern materials can be used to foster this aspect.

In summarizing in a few words what is said above, I would stress that no revolution in hospital planning would appear as an actuality in the future although details in planning might be developed gradually to save personnel. A close study of economic factors might change our opinion as to the most economical sizes and types of hospitals. The development of medicine and the demands that follow upon this must be carefully watched and the planning modified accordingly. Scientific studies and research must develop to give more knowledge as to the size and capacity of the treatment departments in order to co-ordinate them in giving maximum service to the hospital as a whole. Last but not least, the architectural details of the hospital must be carefully considered to give the whole hospital the character of a home and not of an institution.

The modern kitchen in the Sahlgrenska Hospital gleams in stainless steel.

A Sampling of

Canada's from Coast

On Toronto's University Avenue is the New Mount Sinai Hospital. It contains 307 beds and was opened in August, 1953. Architects were Kaplan and Sprachman, Toronto; and Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, also of Toronto.

The Nora-Frances-Henderson Division of the Hamilton General Hospital in Hamilton, Ont., was formally opened in October, 1954. It contains 328 beds. The architect was J. D. Kyles, of Kyles and Kyles, Hamilton.

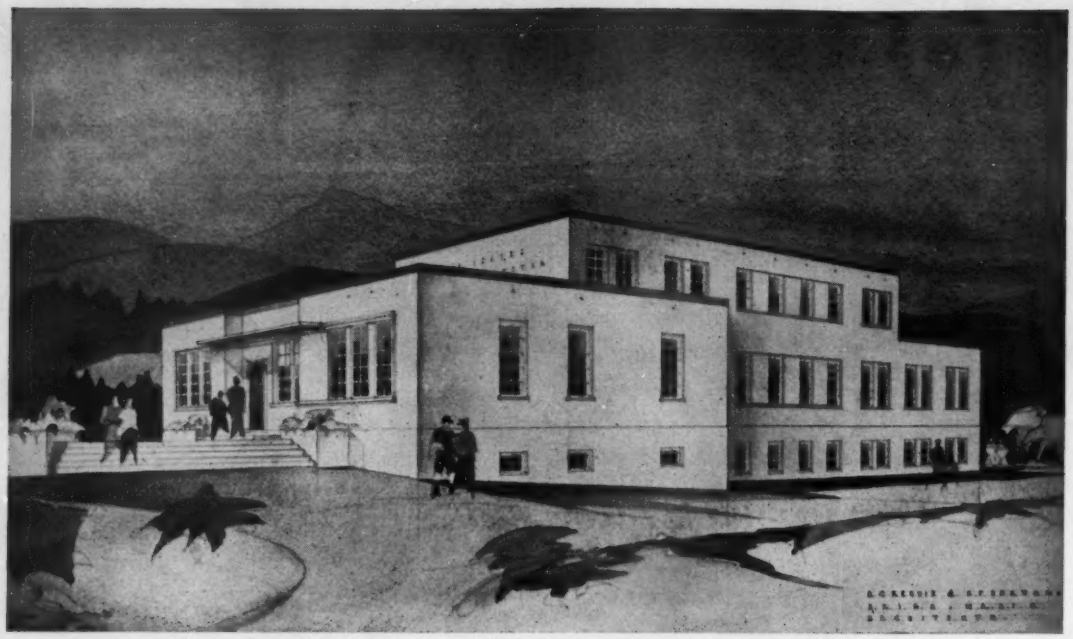
See pages 40 to 46

Hospitals to Coast

The Penticton Hospital, Penticton, B.C., has 121 beds and was opened in March, 1953. Architects were: Mercer and Mercer, Vancouver.

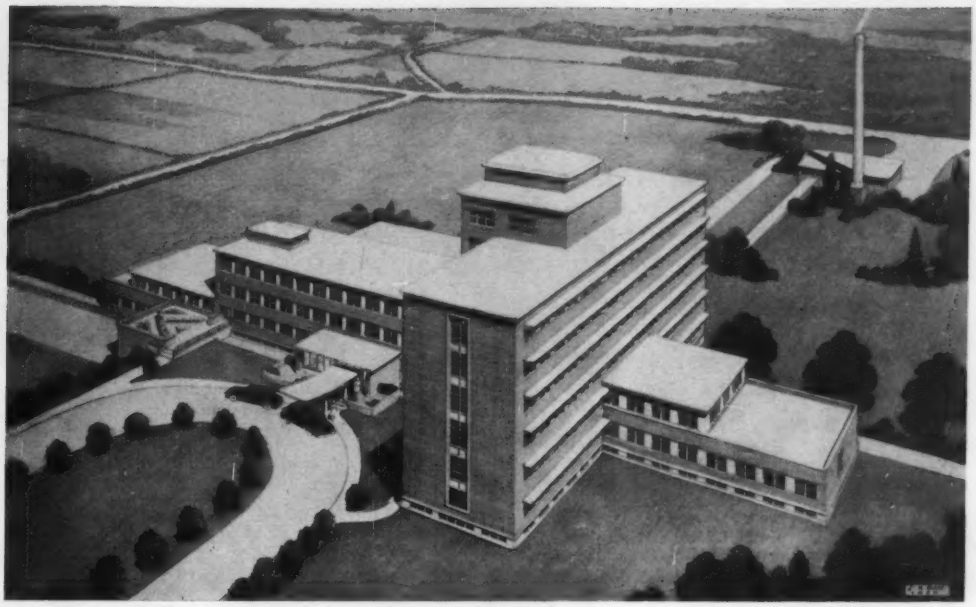
The new Hôpital Ste-Justine in Montreal will contain over 800 beds when it is completed. Architects are Joseph Sawyer and Henri Labelle of Montreal.

Fishermen's Memorial Hospital in Lunenburg, N.S., has 35 beds and opened in July, 1952. Architect: C.St. J. Wilson, Halifax.



This architects' sketch shows the new St. Lawrence Memorial Hospital in St. Lawrence, Newfoundland. The hospital has a special history. It was built by the Government of the United States in gratitude to the people of St. Lawrence and Lawn who aided in the rescue of American sailors during World War II. The hospital has 12 beds and was opened in June, 1954. Architects were: H. G. Rennie and R. F. Horwood, St. John's, Nfld.

New 10-storey addition to Hôpital Ste-Jeanne d'Arc in Montreal. In this building, new beds are provided as well as enlarged operating room facilities, dispensaries, laboratories, and other services. Gaston Gagnier of Montreal is the architect.



The Moncton Hospital in Moncton, N.B., has 210 beds. Official opening was in July, 1953 and architects were: Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto.

The Sudbury General Hospital of the Immaculate Heart of Mary was opened in October, 1950. It has 316 beds. The architect was Louis N. Fabbro of Sudbury.

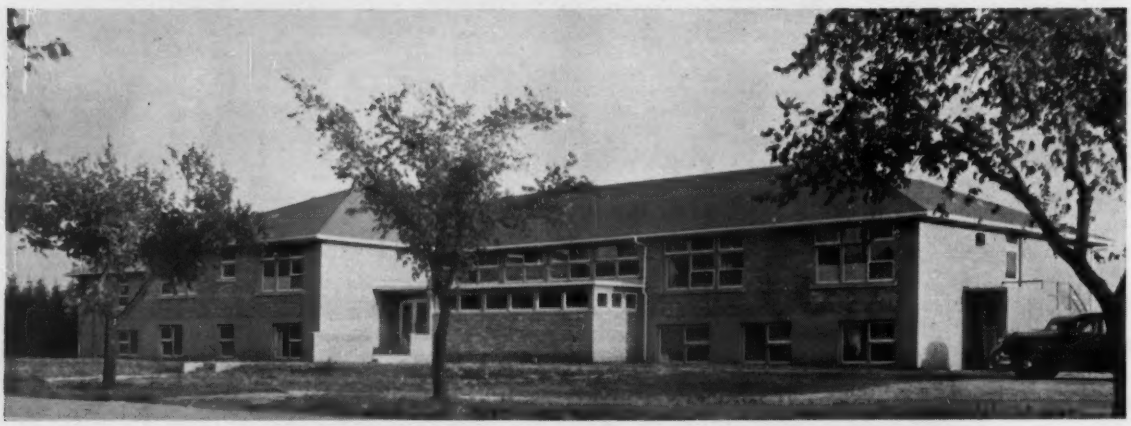
The Hospital for Sick Children, Toronto, was opened in January, 1951. Architects were: Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto. The hospital has 762 beds.

The 626-bed Calgary General Hospital in Calgary, Alta., was opened in March, 1953. Architects were W. L. Somerville, McMurrich, and Oxley of Toronto; associate architects were Stevenson and Dewar of Calgary.

The Guelph General Hospital in Guelph, Ont., has 167 beds. It was officially opened in July, 1951. Architects were Marani and Morris of Toronto.

The Hotel-Dieu Hospital in St. Catharines, Ont., has 146 beds. It was opened in the spring of 1954. The architect was Chester C. Woods, Toronto.

The Swift Current Union Hospital in Swift Current, Sask., was officially opened in June, 1952. It contains 114 beds. Architect was H. K. Black of Regina.



Opened in July, 1952, the Morden District General Hospital in Morden, Man., has 52 beds. It was designed by Moody and Moore of Winnipeg.

There are 154 beds in the Alberta Red Cross Crippled Children's Hospital in Calgary, Alta., opened in March, 1951. Architects: Somerville, McMurrich and Oxley, Toronto.

Pertaining to Paint

H. G. Hughes,
F.R.A.I.C., A.R.I.B.A.,
Chief, Hospital Design Division,
Department of National Health and Welfare,
Ottawa

WE ARE ALL aware of the tremendous developments in medicine during the past half century. It is perhaps presumptuous to compare the progress of an industry with the dramatic relief of suffering which science and research have provided in the field of health. However, some advances in industries have also been spectacular in their own field and the happenings in the development of new paints have been interesting, to say the least.

Let us first take a very fleeting glance at the past and we will find that 20,000 years ago cave men used paint. The early Egyptians developed binders such as gum arabic, gelatin and beeswax. They used iron oxide and applied gold leaf. Then the Romans introduced white lead and red lead. In Asia we find they used such binders as shellac, gum arabic and tree saps. One such sap is still used in the Orient to make Chinese and Japanese lacquer. From Mediaeval Europe in the 6th century came the suggestion that oil be used to make varnish; and in the 11th century came the first description of preparing a varnish by dissolving molten resin in hot oil.

Egg albuminium was the traditional binder of the artist until about the time of the Renaissance when linseed oil was used in preparing varnishes from amber and sandarac. Such artists as Rembrandt used varnish as a medium or as a protective glaze.

Watkin, in 1773, was the first to describe any form of paint industry, and his book on varnish formulations was considered a standard until the beginning of this century. From this date onward, new raw materials and scientific methods developed rapidly.

Advertisements tell us of "wonder" paints which have been appearing on the market; and it is hoped that a short discussion of the development of some of. these newer materials, their potentialities and uses, might be of interest to those responsible for maintenance in hospitals.

Recent Developments

In the past it was customary for an architect to specify lead in oil paint for exterior use. I am afraid this can still be found in some specifications; but ten to one that is not what the painting contractor will provide.

Let us attempt to trace some of the developments which have occurred in recent years from the lead in oil era and some of the properties of these new products. In the course of time new pigments were developed and it was found that, through the use of these, the deficiencies of straight lead pigmentation could be eliminated. Lead in oil paint will discolour with sulphur conditions in the air such as are found in industrial areas. It has nothing like the covering-capacity of the later developments and it takes considerably longer to dry.

The Author

Zinc oxide and zinc sulphide, and lithopone, were developed as pigments. White lead is soft, zinc oxide is hard, and one property of lithopone was that it seemed to turn grey on a dull day; therefore a combination of the three was commonly used in paint.

Then, eventually, titanium oxide was developed. There are different grades of this substance. The present-day practice is to combine titanium, lead and zinc oxide, plus extenders, to give a good balance of properties which include good opacity, durability and colour.

It should be noted that a good paint should not deteriorate by cracking or by forming an "alligator" skin appearance, but rather by chalking and gradual erosion. However, excessive chalking is also to be guarded against.

From the development of oil soluble phenolic resins and the introduction of tung oil came a water-resistant finish which was quick drying. We know it, among other things, as a spar-type of varnish, used initially for spars on boats. It is also used in enamel for its water-proof qualities.

Nitro-cellulose Lacquers

The development of these lacquers occurred after World War I when explosive manufacturers wished to maintain their production facilities for nitro-cellulose. They were also the outcome of a need for a quick drying coating. They were first used on motor cars but now have many other uses in industry. Lacquers generally must be sprayed on and require strong solvents. They are not used for exterior wood surfaces but have proved excellent for furniture where they are widely used. They are also used extensively on metal, for instance, on automobiles, aircraft equipment and small parts.

Alkyd Enamels

Alkyds are one of the most important of a series of synthetic resins which have been developed to meet the demand for good drying durable finishes. These are very widely used in trade and industry. The alkyds have good all-round properties and durability. They can be obtained as interior flat which dries in four to six hours; semi-gloss and gloss which

(Concluded on page 58)

Edmonton plays host to tenth

Western Canada Institute

Jane E. McNally

THE RIGHT tune and tempo was set for the tenth Western Canada Institute for Hospital Administrators and Trustees, June 13th to June 17th, when Dr. L. O. Bradley, Calgary, who presided over the opening session, suggested to listeners that they try the "back to school" approach. This seemed to be a challenge to those eager hospital people who had journeyed from four western provinces to Edmonton, Alta., and the campus of the University of Alberta, for the five-day program which was packed with a variety of stimulating and interesting addresses.

A discussion of hospital organization and management was the topic chosen for presentation on Monday. Leading off on "The Art of Management" was Professor Earle D. MacPhee, director of the School of Commerce, University of British Columbia, Vancouver. Basically we learn from one another and we should look on management as the art of handling people, stated Prof. MacPhee. Handling managerial problems and having technical competency are two different things. Administrators are primarily engaged for something other than technical competency. Prof. MacPhee emphasized that people who assume leadership must know what the goals are and must turn the goals into plans and programs.

Management must motivate and inspire, the speaker said. A common goal of management is to divide jobs, divide responsibility and authority. How they are divided and grouped depends on the complexity of the job. "We all do a poor job of delegation", stated Prof. MacPhee. He indicated that we don't trust people enough. If people have the right qualifications for a job, in Prof. MacPhee's opinion they should be trusted with responsibility for that job. In conclusion, Prof. MacPhee reminded his audience that "every person has the right to satisfaction in a job."

Judge J. Milton George, Morden, Man., presided over the afternoon session, which continued on the broad topic of organization and management. He stressed the value of the institute and all that was to be learned from such a gathering. "Never admit we know it all", mused Judge George as he expressed delight that so much of the program for the

Among the faculty members were, seated left to right, Mrs. Jeanne Welsh, and Ruth Crawford, both of Calgary, Alta. Standing, left to right, H. Gordon Hughes, Ottawa, and Dr. W. Douglas Piercey, Toronto, Ont.

institute was directed to help the small hospital.

Before launching into his topic for the afternoon, Dr. J. Gilbert Turner, Montreal, president of the Canadian Hospital Association, brought greetings from the national association. Following this he described how to attain sound and certain hospital organization. Dr. Turner expressed the opinion that the small hospital administrator has to "carry the ball" more by himself. Community interest in the hospital must be sought and maintained as it is the community to whom administrators are responsible. After all, Dr. Turner pointed out, it is the community which is asked to finance the hospital.

Every organization should have bylaws and regulations, he continued. "Do not hesitate to revise and review" was some of the good advice which Dr. Turner passed on to the students. Another thought which was expressed was that the medical staff should be self disciplined. It is an obligation of the administrator to see that they are self disciplined. Switching to review the work of hospital trustees, Dr. Turner thought there was a need for trustees to get together more. He liked the idea of a three-year term for trustees and he thought that a medical man should be on the board. Moreover, proclaimed Dr. Turner, there should be only one boss in the hospital and that boss is the administrator. The board has no right to give orders to the administrative staff and should not have any relationship with department heads.

Speaking on "Special Problems in Hospital Administration", Dr. W. Douglas Piercey, executive director, Canadian Hospital Association, Toronto, Ont., commented that "if we had no problems we wouldn't need an administrator". He likened the administrator to a general manager in a business concern. The administrator has as his goal better patient care and to accomplish this there must be staff training. Dr. Piercey again pointed out that there can be only one head of the hospital. In his opinion, the administrator must have certain managerial qualities and since he must keep his finger on the work of all departments he must not be bogged down with paper work. The administrator is hired to think, said he.

The board sets the policy, continued Dr. Piercey, and the administrator carries it out. He advised his audience to take problems to their boards at once and not wait until they had heard about them from other sources. Public relations, he said, start with a satisfied staff and, in turn, satisfied patients. Surround yourself with good loyal people who form a team, advised the speaker.

Representatives attended from near and far. Left to right: John Smith, Yorkton General Hospital, Yorkton, Sask.; Dr. I. Sutton, Deer Lodge Hospital, Winnipeg, Man.; and Dr. Crosby Johnston, University of Alberta Hospital, Edmonton.

In his speech "Unions Come to Hospitals", Professor G. W. Reed, associate professor of law, University of Alberta, Edmonton, gave a factual picture of what a union means. He said that a union was an organization of employees formed for the purpose of regulating rules between the employer and the employee. Prof. Reed gave as the sociological reason for having a union that there was an ever widening gap between the employer and the employee. Stating that hospitals have an idea of service which industry doesn't have, he suggested, however, that dishwashers, for instance, aren't so much in touch with the idea of service.

Prof. Reed described the steps which would take place when a union comes into force. Under the law, an employer must not interfere with the organizational drives of a union. While the union will probably involve cost to the hospital, it was pointed out that collective agreements can bring more effective stabilization of staff. Prof. Reed told his audience not to be fearful of unions and not to underestimate the people who represent them. He warned employers to have the facts and figures at their finger tips because the union will be well prepared. Bargaining is a practice of give and take and he challenged all to be firm "but avoid hostility".

Speaking again in the afternoon, Prof. Earle MacPhee stated that one weakness often found in hospital

Dr. L. O. Bradley, Calgary, Alta., chairman of the program committee chats with, left to right: Sr. B. Bezaire, Edmonton; Miss M. M. Sissons, Vulcan, Alta.; and L. R. Adshead, Edmonton.

From Saskatchewan were, left to right: Dr. John Wong, Saskatoon; Dr. Burns Roth, Regina; Dr. Irial Gogan, Regina; Dr. A L. Swanson, Saskatoon; Phillip Richard, Swift Current; and J. L. Fawcett, Rosthern.

H. P. J. Gunn, Vancouver, is seen in discussion with, left to right: W. P. Howe and E. G. King, both of Lloydminster, Sask.; and Noreen Flanagan, Medicine Hat, Alta.

Four of the Sisters attending the Institute are pictured here. Left to right: Sr. Louis Gerard, Spirit River, Alta.; Sr. Mary Anna, Winnipeg, Man.; Sr. St. Gilbert and Sr. St. Laure, Edmonton.

From the four western provinces are, left to right: B. H. Haaland, Regina, Sask.; E. Shaw, Vancouver, B.C.; Arthur Hodgkinson, Winnipeg, Man.; Dr. D. R. Easton, Edmonton, Alta.; and Gordon Frith, Nanaimo, B.C.

J. D. Campbell, Department of Accounting, University of Alberta, Edmonton, is shown here with, left to right: Robert Goodman, Winnipeg, Man.; J. Ellison, Edmonton; I. Bond, Edmonton; and Menzie Dyck, Calgary, Alta.

Between sessions, this group was caught by the camera. Left to right: Sr. Alcide Marie, Fort Vermilion, Alta.; S. V. Pryce, Calgary, Alta.; Sr. Miriam of Jesus, High Prairie, Alta.; and A. Wallmark, Cold Lake, Alta.

Patricia McGrath, Regina, Sask., chats with, left to right: Miss K. E. Thompson, Regina, Sask.; Ian Douglas, and Barry Jeffrey, both of Calgary, Alta.

Left to right: Mrs. E. White, Hanna, Alta.; Miss O. Stasiuk, Provost, Alta.; Mrs. Jean Hammer, Olds, Alta.; and Kenneth Temple, Winnipeg, Man.

management was the failure of the board of trustees to define their policies. The board must know the policies of the hospital and he urged that there was no better use of an administrator's time than to explain to the board the policies already established. The fact that administrators come from a variety of backgrounds was unimportant in Prof. MacPhee's opinion. The chief administrative official cannot afford the time to do detailed planning for any department.

An excellent feature of this year's institute was that, at the end of each session, time was allotted to a discussion on how to apply the principles brought out during the day to the small hospital. James Mainguy, manager, hospital consultation and inspection division, British Columbia Hospital Insurance Service, summed up the day's proceedings and many representatives from the smaller hospitals availed themselves of the opportunity to ask questions.

Medical Care

Ways and means for improving the quality of medical care in hospitals came under review during the Tuesday morning session, which was presided over by Dr. A. L. Swanson, executive director, University of Saskatchewan Hospital, Saskatoon.

Dealing with "Medical Staff Organization to Meet Improved Standards", Dr. J. Gilbert Turner, administrator, Royal Victoria Hospital, Montreal, thought that the medical staff should be organized with one head even if there were only two doctors. He felt that self discipline and the development of standards of care were important points in improving medical care. Dr. Turner was also of the opinion that medical men themselves should pass judgment on their own colleagues. As the medical staff increases in number committees should be set up to carry out policies. Departmental organization is most necessary. The medical staff should meet regularly and minutes should be kept of these meetings. In Dr. Turner's opinion the administrator should attend the medical staff meetings. Loyalty between the medical staff and the administrator will do a great deal to improve medical care in hospitals, he said.

"Who Controls the Doctor in Hospitals" was discussed by Dr. W. Douglas Piercey. He emphasized that a beautiful, well located hospital doesn't make a good hospital. There must be something more. The board of trustees, the administrative staff, and the medical staff all must have the interest of the patient at heart. Every hospital should find out what the program for accreditation has to offer. The hospital board's primary function is to seek better care of the patient and therefore the board must have an interest in what the medical staff is doing. The administrator is the liaison between the board and the medical staff. On one hand he must keep the board informed about matters pertaining to better medical care. On the other hand he must keep the medical staff aware of what is going on in the hospital generally. Dr. Piercey said that the yardstick for judging medical care was reviewing cases and having consultations. On both sides it is a matter of education and therefore slow progress can be expected.

Speaking for the hospital board, Dr. W. Ross Upton, a member of the Calgary General Hospital board, Calgary, took the point of view that it was the board which has the responsibility to control the medical staff. He stated that medicine was before the public more and more and that members of the board were obliged to educate themselves in these matters. The trustee is morally and sometimes legally responsible for good patient care. He felt that the board member in a small hospital has to be more alert to medical problems than his city counterpart. One way that the trustees could help the medical staff was by providing a good medical library for them, he said. Dr. Upton summed up his remarks with the statement "the best way to receive co-operation is to give it".

Dr. Walter C. MacKenzie, professor of surgery, University of Alberta, Edmonton, expressed the view that doctors must exercise self discipline. He felt that the governing board did have a responsibility, both legally and morally, for the welfare of the patient but that board members were not competent to judge medical care. The medical staff themselves must audit the medical care and discipline the doctors. Again, the necessity to have committees to review the medical staff's work was emphasized. Dr. MacKenzie thought that a modification of the same principles for staff organization could be applied to the small hospital. Every effort should be made to obtain a higher percentage of post mortem examinations. He felt that the public should be educated to the fact that no good doctor fears the result of a post mortem examination. In the case of small hospitals, he said, the board of trustees could obtain help on medical problems from the provincial college of physicians and surgeons.

A need for both internal and external evaluation of hospital work was revealed in the question period which followed. The questions were

(Continued on page 60)

From Misericordia Hospital, Edmonton, were left to right: T. Delwo; Sr. St. Solange; and A. H. McLean.

Maritime Hospitals Convene in Charlottetown

From the left are: Col. Leo F. MacDonald, Charlottetown; W. D. Morton, Mayor of Windsor, N.S.; and Dr. D. F. W. Porter, Moncton, N.B.

OVER 400 delegates and friends of the Maritime Hospital Association assembled in Prince of Wales College, Charlottetown, P.E.I., on May 31st, for their 13th annual convention. Meeting concurrently were the Maritime Hospital Aids Association and the Maritime Hospital Exhibitors' Association. The four-day convention was preceded by an executive meeting of the Association on May 30th.

In the course of his remarks at the opening session, His Worship J. D. Stewart, D.S.O., Mayor of Charlottetown, said: "We consider it a great honour that you have chosen Charlottetown this year as the city for your deliberations. This being our centennial year, we naturally look back into the past. There we find that The Charlottetown Hospital was opened on Dorchester Street near St. Dunstan's Cathedral in the year, 1879; also in the same year, the present mental hospital at Falconwood opened. Five years later, the Prince Edward Island Hospital opened. Our Provincial Sanatorium was opened in 1931.

"Charlottetown feels proud of its hospitals . . . We are proud also that we are part of the Maritime Hospital Association for we fully realize that, through this organization, benefits derived will be shared by all for the welfare of those who have found a haven within the confines of our hospitals. This has been made possible to our citizens by you.

"The administrative branches of our hospitals are possibly doing the greatest work in the community. An organization composed largely of non-paid boards of directors, hospital ladies' aids . . . . are all working in unison for the proper care of our sick. Good management and administration ensures success . . . . By having discussions of each other's problems, and exchanging ideas at conventions, benefits must accrue to all hospital boards.

"Too many of us are prone to forget such things as community service and it is only at times such as this that we realize what people like you are doing for mankind. We are proud of you—we are privileged to have you with us. Yours is a noble task."

Provincial Hospital Plans

One of the interesting addresses of the meeting was that given by Dr. Gordon E. Wride, principal medical officer, National Health Grants, Department of National Health and Wel-

Among officers elected for 1955-56 are the following: Seated, left to right: Jean Lynds, Newcastle, N.B., representative of the Nurses' Association of New Brunswick; Mayor Gladys Porter, Kentville, N.S., secretary-treasurer; R. H. Stocker, Corner Brook, Nfld., president; R. W. Skeat, Moncton, N.B., past-president; C. M. Carpenter, Moncton, president, Maritime Hospital Exhibitors' Association.

Standing: Dr. E. Wilson, St. John's, Nfld., vice-president for Newfoundland; Dr. J. A. MacDougall, Saint John, N.B., representative of Maritime Hospital Services Association; Mayor W. D. Morton, Windsor, N.S., executive member; Neil D. MacLean, Charlottetown, executive member for P.E.I.; Col. Leo F. MacDonald, Charlottetown, vice-president for P.E.I.

Left to right: Mother Loyola, Charlottetown; Mother Ignatius, Antigonish, N.S.; Dr. J. A. MacMillan, Charlottetown; Sister M. Veronica, Saint John, N.B.; Sister Paul of the Cross, Antigonish; Sister Mary David, Charlottetown; Sister Leonard, St. Joseph's Hospital, Saint John, N.B.; Sister Mary Irene, Charlottetown.

Hospital Exhibitors' Association officers are, left to right, front row: C. M. Carpenter, Moncton, N.B., president; R. W. W. Brown, Moncton, secretary-treasurer. Standing are the directors, for P.E.I., Lloyd Parlee, Charlottetown; Quebec, Paul Flemming, Montreal; Ontario, George Sharpe, Toronto; New Brunswick, G. M. Lestage, Moncton; Nova Scotia, Roy E. Veake, Truro.

Among Nova Scotians were, front row, left to right: John Flynn, Glace Bay; A. R. MacDonald, Antigonish; Sister M. Anias, Glace Bay; Major LaRose, Major Strickland, and Rhoda MacDonald, all of Halifax.

2nd row: John Mackin, Glace Bay; Sister M. Clarissa, Sydney; Sister Jean Annett, Sydney; June McGillivrary, New Waterford; and Jean Adams, Sydney Mines.

3rd row: Cyril McEachern, Kentville; Rev. M. J. MacAdam, Inverness; Ann Martin, Sydney; Sister Annunciata, Glace Bay; and J. H. Beaton, Inverness.

Back row: F. F. Graham, Middleton; L. J. Jessome, Sydney Mines; Robert Muir, Sydney Mines; E. Hodge, Yarmouth.

A group of P.E.I. delegates are, from the left: Sister Mary David: Sister Mary of Good Counsel; Charles Praught; Judge Des-Roches; J. E. Cullen; Mrs. Lois MacDonald; M. A. Farmer; Mrs. Heath Strong; Dr. J. P. Sweeney; Mrs. MacLellan; Col. L. F. MacDonald; Neil D. MacLean; and Dr. J. W. MacKenzie.

All photos by Barter's Film Lab., Charlottetown.

fare. He reviewed the history of the compulsory pre-payment hospitalization plans which are operating in British Columbia, Alberta, and Saskatchewan. In British Columbia, he pointed out, the plan began in January, 1949. With a population of over 1,250,000 and a booming economy, there are about six general hospital beds per 1,000 people. The province of Saskatchewan, with a population of over 850,000 and a precarious economy, has about six beds per 1,000 people. This province, above all others, had carried out intensive planning and regionalization for all health services, using hospitals as strategic local health centres.

In Alberta, Dr. Wride explained, the population is rapidly growing, with over a million persons at present, and there is a buoyant economy. There are about six acute hospital beds per 1,000 persons. A new plan for medical care is also being introduced in Alberta. In describing this plan, briefly, Dr. Wride stated that the province will pay to the Medical Services Plan of Alberta (operated by physicians) one-third of the premium set by that plan for each enrolled resident of Alberta. In return, the Medical Services Plan or any other insurance group will attempt to increase enrolment without compulsion among the residents of Alberta.

Other Speakers

Other highlights of the general sessions included a panel discussion on important phases of nursing, under the title of "Staff for Nursing Service". Chairman of this group was Kathleen Harvey, Reg.N. Another round table discussion was devoted to Blue Cross, under the leadership of Andrew J. Likely of Charlottetown, while still another group considered questions of general interest. The latter included: Colonel Leo F. MacDonald of Charlottetown as chairman; Dr. D. W. Porter of Moncton; Walter W. B. Dick of Moncton; Dr. Mary Johnston of New York, N.Y., and Dr. W. Douglas Piercey of Toronto. As executive director of the Canadian Hospital Association, Dr. Piercey also addressed the general meeting on two topics of national interest—hospital accreditation and the two C.H.A. extension courses, one in hospital organization and management and the other for medical records personnel.

Trio of Newfoundland delegates, all from St. John's are, left to right: Dr. E. Wilson, superintendent, St. John's General Hospital; Brig. H. Janes, superintendent, Grace Hospital; and Capt. M. Lydall, director of nurses, Grace Hospital.

Business sessions of the convention were well attended and provoked active discussion on several topics of immediate concern to the Association. In addition to the reports of the president, R. W. Skeat of Moncton, and the secretary-treasurer, Mrs. Gladys Porter of Kentville, N.S., each province held its own sectional meeting. At these meetings, attention was given to problems primarily of provincial concern and recommendations and resolutions were formulated for presentation to the Association. An extra evening session was devoted to the consideration of a report recently made available by a joint commission appointed by the Maritime Hospital Association and the Maritime Hospital Service Association (Blue Cross) to discuss problems of mutual interest. Considerable time was devoted to the advisability of a full-time secretariat to act as liaison between the Maritime hospitals and Blue Cross and to promote other Association activities. The matter was left to the in-coming executive for detailed study.

Aids and Exhibitors

The Maritime Hospital Aids Association met for two days in the library of the Prince of Wales College, under the chairmanship of Mrs. B. L. Moran of Chatham, N.B., president (See page 70). The Maritime Hospital Exhibitors' Association also held their annual meeting. Some 41 members of this association displayed exhibits during the hospital convention. Their displays were well attended by delegates to the convention and, as a whole, the exhibitors did much to make the convention a success.

Special Events

One of the special events of the meeting was the presentation of a golden key and chain of the city of Charlottetown to R. W. Skeat, president of the Association, by His Worship, Mayor J. D. Stewart, D.S.O. This took place at the convention banquet. Mrs. Gladys M. Porter, mayor of Kentville as well as secretary-treasurer of the Association, was presented with a Queen Charlotte doll by Mrs. Stewart, wife of the mayor. Since Charlottetown is, in 1955, celebrating its centenary, the city was gaily decorated with flags and coloured lights.

The guest speaker at the convention dinner was Dr. L. W. Shaw, deputy minister of education for the province of Prince Edward Island, who took as his subject—"Hospitals are People". Dr. Shaw reminded his audience that the English word, "hospital", comes from the Latin *hospitium*, which means a place to receive guests. The speaker traced the origin of hospitals prior to Christianity and pointed out that the humanitarian aspect of hospitals did not develop fully until the advent of Christianity. Dr. Shaw contended that good public relations were needed by all hospitals

(Concluded on page 88)

Alberta Hospitals in Annual Convention

SOME 210 delegates and visitors registered for the 12th annual convention of the Associated Hospitals of Alberta which was held, on June 10th and 11th, at the University of Alberta, Edmonton.

In his presidential report, Dr. D. R. Easton, superintendent of the Royal Alexandra Hospital in Edmonton, devoted some time to the nursing situation in the province. He stated that the number of applicants for the province's schools of nursing is increasing and that training programs are improving. Unfortunately, he continued, the provincial government's allowances to hospitals for nurses-in-training are "far from realistic". At present, the provincial department of health makes an allowance of $300 for each student nurse who graduates from schools of nursing. The average cost to the hospital for training each nurse is $250 per year. Dr Easton felt that the government should be approached by the association's board of directors for higher subsidies.

Presenting the report of the economics committee, its chairman, S. V. Pryce, business manager, Holy Cross Hospital in Calgary, emphasized that there was a need to make government rates, payable to hospitals under the $1-a-day plan, more realistic. Present rates are based on an average cost for each group of hospitals. He felt that a new basic rate should be set which would reflect the budgetted increases for the year and would be in line with current costs. Speaking from the floor, Dr. L. O. Bradley, administrator of the Calgary General Hospital, was of the opinion that hospital rates should be set by the association, not the government.

L. R. Adshead, secretary-treasurer of the Associated Hospitals of Alberta, told the delegates that this year's convention had attracted the largest number of firms sponsoring exhibits—37 in all. He also stated that the organization of regional districts was largely completed with the province being divided into nine such areas.

Reporting on the Alberta Blue Cross Plan, J. A. Monaghan, executive director, stated that "membership in the plan is at the highest level in its history". Furthermore, he said, that Blue Cross was actively engaged in extending existing services.

Mrs. E. Wershof, Edmonton, acting president of the Associated Auxiliaries of Alberta, reported on the work of the province's hospital auxiliaries — see page 70.

During the Friday afternoon session, Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association, described the various activities of the national organization. He spoke in detail of the two extension courses, one in hospital organization and management and the other in medical records. Consideration is being given to the establishment of a course in accounting, Dr. Piercey pointed out.

J. D. Campbell Ph.D., professor of economics, University of Alberta, Edmonton, reviewed the subject of uniform accounting for the delegates. He explained that accurate data was necessary to gain a firm insight into what is happening in hospitals. In the discussion period which followed, delegates unanimously endorsed the principle of setting up a new flat rate schedule.

At the annual banquet, which was held on Friday evening, Dr. A. C. McGugan, administrator of the University of Alberta Hospital in Edmonton, was presented with a special citation by the Associated Hospitals of Alberta for his sincere and heartfelt efforts on behalf of the hospitals of the province. Guest speaker at the banquet was Ernest Watkins, former B.B.C. commentator, who spoke on international affairs.

Members of the newly-elected executive of the Associated Hospitals of Alberta are shown here. Front row, left to right: S. V. Pryce, Calgary, first vice-president; William Chessor, Lacombe, president; and L. R. Adshead, Edmonton, secretary-treasurer.

Back row, left to right: L. MacArthur, Peace River; W. Crook, Brooks; Dr. H. P. Wright, Calgary; Sr. M. Immaculata, Lethbridge; Dr. D. R. Easton, Edmonton, immediate past-president; Sr. B. Knopic, Edson; G. W. Hollingshead, Edmonton; and J. Cramer, Drumheller. Absent when picture was taken, Noreen Flanagan, Medicine Hat.

On Saturday morning, Dr. M. G. McCallum, director of Hospital and Medical Services for the province of Alberta, answered questions put to him by the delegates. In the afternoon, George Debonnaire, instructor, School for X-ray and Laboratory Technicians, described the new six-month course for training personnel for smaller hospitals in x-ray and laboratory procedures. The course commenced in January of this year and is sponsored by the Alberta Department of Public Health, with the aid of federal health grants.

Resolutions

Most of the program on Saturday was devoted to a presentation of resolutions under the chairmanship of Judge Nelles V. Buchanan. Some of these were as follows:

WHEREAS the placing of responsibility for the payment of accounts of transient indigent patients is a recurring and persistent problem for all hospitals,

NOW THEREFORE BE IT RESOLVED that our directors arrange for the attendance at all our annual conventions of a senior official of the Department of Public Welfare, equipped to discuss that Department's responsibility for transient indigent accounts.

WHEREAS there is great variation in the periods during which hospitals deem it advisable or compulsory to preserve hospital records;

AND WHEREAS their preservation taxes the available storage space of many hospitals,

THEREFORE BE IT RESOLVED that the directors advise all member hospitals as to their legal responsibility, if any, for the preservation of hospital records and as to the period thought most advisable.

WHEREAS by 1954 amendment to the Municipal Capital Expenditures Loans Acts, it was made possible for the Provincial Treasurer to "make loans for the purpose of assisting in the construction, extension, or improvement of hospitals";

AND WHEREAS the word "hospitals" in the said amendment has been interpreted by the Provincial Treasurer as applicable to buildings in which patients are housed;

AND WHEREAS to be of maximum benefit to hospitals, the Act should provide for loans respecting all hospital buildings and particularly nurses' residences;

AND WHEREAS the said Act is not specifically made applicable to municipal hospital districts;

NOW THEREFORE BE IT RESOLVED that the Board of Directors seek an amendment to the said Act, enlarging its application to include nurses' residences and to be specifically applicable to municipal hospital districts, or to corporations operating voluntary hospitals.

WHEREAS Associated Hospitals of Alberta has been successful in drafting a standard insurance claim form which has proven acceptable to the insurance companies;

AND WHEREAS Alberta Blue Cross, the creation of Associated Hospitals of Alberta, uses a claim form more difficult and complicated than that drafted by the Association, the completion of which by hospital staffs is a veritable pain;

NOW THEREFORE BE IT RESOLVED that the executive director appear before this annual convention and explain why, what is thought good enough for the corporation and insurance companies, is not likewise good enough for him.

WHEREAS the present standard ward care under the one-dollar-per-day agreement has been defined as follows: "The bed accommodation provided to the patient when private or semi-private room accommodation has not been requested and including the routine services such as meals, nursing care, drugs, medication and dressings ordinarily provided without extra charge"

AND WHEREAS the Associated Hospitals of Alberta has not fully listed what drugs, medications and dressing should be provided in standard ward care;

NOW THEREFORE BE IT RESOLVED that the economics committee be requested to prepare a list of standardized routine drugs, dressings, et cetera, which should be included in standard ward care for the various classes of patients who are under contract, such as ratepayers, pensioners, and maternity patients.

WHEREAS in the pursuit of what our board of directors deemed a sound financial objective, it sought and obtained an interview with the Provincial Cabinet and presented to it a substantial brief on hospital rates;

AND WHEREAS in this convention's opinion, this step was wise and had beneficial results;

NOW THEREFORE BE IT RESOLVED that for its initiative in so attending upon the Cabinet, we heartily recommend our Board of Directors.

WHEREAS the Directors have made representations to the Government of Alberta as outlined in their brief dated January 14th, 1955 and

WHEREAS this convention unanimously endorsed the principle of a flat, all inclusive rate schedule for payment of hospital accounts,

NOW THEREFORE BE IT RESOLVED

(1) That the Board of Directors be instructed to continue their efforts to establish adequate rates for payment of hospital services;

(2) That the Board make every effort to secure the establishment of these rates on the specific principles outlined in the Brief of January 14th, 1955.

WHEREAS hospital management and control is of primary importance to the patient, and

WHEREAS the competent matron-superintendent of a rural hospital must have adequate training and education for her position,

NOW THEREFORE BE IT RESOLVED that the Associated Hospitals of Alberta request the Department of Public Health to give serious consideration to the organization and sponsorship of an annual matron-superintendent accreditation course.

WHEREAS Section 5, sub-section (2) of The Hospitals Act reads as follows:

"Every local authority may in cases of sudden and urgent necessity make similar provisions for indigent sick persons who are temporarily within the area controlled by it but are not residents therein" and

WHEREAS subsection (8) of the same section reads as follows:

"Where, under the provisions of this section a local authority causes to be treated any indigent sick person who is not a resident of the area controlled by it, then the local authority of whose area the said person is a resident at the time of such treatment being given shall upon demand repay the

(Concluded on page 96)

Pertaining to Paint

(Concluded from page 47)

will dry in eight to eighteen hours. They can be used for interior or exterior work for a wide range of surfaces and objects. They can also be supplied as odourless paint, as is the case with most paints. The smell in paints comes mostly from the solvents.

Chlorinated Rubber Paints

Another synthetic resin is chlorinated rubber, which is no longer rubber because the chlorination changes its molecular structure. They are chemically-resistant coatings particularly for use in humid locations such as paper mills, dairies, and food processing plants. They are resistant to alkali and moisture and are used as corrosive-resistant paints.

They are useful on plaster or concrete floors where moisture is a problem and have good wearing properties; but they are not resistant to strong solvents. It is suggested that in areas where there is a high concentration of moisture as in dishwashing areas or where an autoclave is causing deterioration of plaster above it, this material would be satisfactory. It has been used with success on swimming pools.

Vinyl Based Paints

These have a high degree of chemical resistance and provide corrosion protection if the surface on which they are to be applied is thoroughly clean. There are many uses in plants and marine service for this type of paint which is normally sprayed.

Latex and Emulsion Paints

One might consider these paints as a development of water bound paints, such as casein and calcimine, which are older than civilization. Chemists have developed suspensions of binding mediums such as oil, varnish, or synthetic resin in water. How one mixes oil and water is a puzzle to most, but evidently not to a chemist. The use of water as the volatile eliminates the use of flammable and odouriferous solvents to dissolve these resins. This has much appeal to homeowners.

The type known as rubber base or latex paint has found great acceptance because of applicability and such properties as washability. This paint can be obtained flat or eggshell for interior use. Its great advantage is that it can be applied to "green" plaster without disintegrating. Certain types can be used as primer and finish coat on exterior concrete and masonry, but the type should be selected with care.

One of the advantages of this type of paint is that it is so easy to apply with a brush or a roller, which can be washed out in water. It is almost odour-free, and shows no laps when properly formulated. The painting trade has been done out of some work and these paints have become a big factor in this "do it yourself" era. Synthetic rubber type base paints are chemically resistant and are used on concrete, walls, and such exposed areas as floors for porches.

Odourless Paint

Hospitals are interested in odourless paint. It is desirable to have a ward painted with a quick-drying, odourless paint so that patients can be returned promptly after the redecorating.

An odourless paint is obtained by the use of an odourless thinner such as mineral spirits. An early attempt to solve this problem was to camouflage the smell with pine oils but the fumes could not be eliminated by this method.

Now unpleasant odours have practically been eliminated, but, no paint is completely odourless. There are, on the market, enamel and semi-gloss paints which have very little odour and which can be used successfully in hospitals. However, it is still a good idea to open the window when painting—it helps drying if outside humidity is not too high.

Fire-Retardent Paints

Fire-retardent paints should be used with caution and in no way should they be expected to supersede normal fire precautions, the best of which is fire-resistant construction.

The principle of some of these paints is that when in direct contact with flames they bubble and form a protective crust. There are various types on the market. Few combine good paint properties with fire-retardent qualities. They would serve their purpose in such areas as attics or those places which have exposed woodwork and where a fire hazard exists. They may be useful in preventing the spread or the start of small fires but would not help when these have become enlarged. It should be recognized that these paints do not produce non-combustible construction.

Multiple-Phase Paint

As children we were told of "striped paint", red and white for painting barber poles! It seems that they have something like that now. Paint of two or more colours can be sprayed on at one time through one nozzle. This is a textured enamel with colour flecks suspended in a film, giving a mottled finish.

Conclusion

Competition among paint manufacturers is keen and behind all satisfactory finishes has been extensive research to develop the product. Choosing the most satisfactory product to solve a particular need can be most difficult. Although many of the newer developments in the paint industry appear to result in a "miracle paint", each of these products has its limitations. Only by having a slight knowledge of their potentialities can we expect to arrive at a satisfactory solution of our painting problems, without an expensive trial and error experience.

Acknowledgements

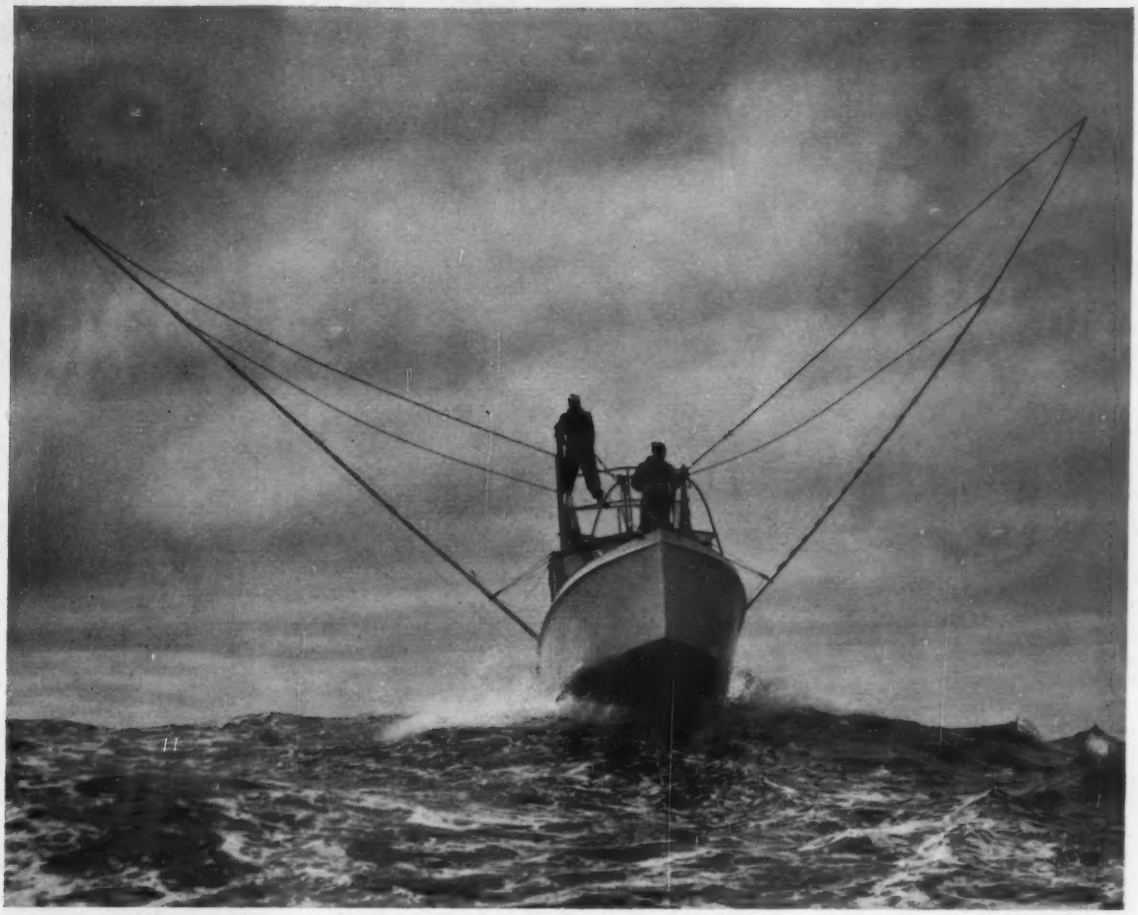
John Harris, B.Sc., Paint Research Laboratory, Division of Building Research, National Research Council, Ottawa.
A. W. McIntyre, Chief Chemist, B.A. Paint Co. Ltd.
Lessing Williams, A.I.A., Architect, New York, N.Y. •

Ontario Regional Council No. 3 Meets

Regional Hospital Council No. 3 of the Ontario Hospital Association met in Palmerston, on May 18th, with 156 members present. The guest speaker at the meeting was Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association, who spoke on the various activities of the national organization. The new executive of Regional Council No. 3 consists of the following: chairman, Eric Winkler, Hanover; vice-chairman, W. T. Brown, Palmerston; and secretary-treasurer, A. T. Story, Owen Sound.

Sanskrit Medical Lore

"It is good to keep water in copper vessels, to expose it to sunlight, and filter through charcoal" is a dictum not out of an engineer's report in 1954, but presumably from a collection of medical lore in Sanskrit of a probable date of 2,000 B.C.—*from "World Health Today", April 7, 1955.*



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(Continued from page 52)

answered by Dr. William Bramley-Moore, registrar, Alberta College of Physicians and Surgeons, and Phillip Sheridan, hospital administration consultant, Saskatchewan Department of Health, Regina.

New Horizons

Presided over by Dr. A. C. McGugan, administrator, University of Alberta Hospital, Edmonton, an interesting session on new horizons in hospital care gave the audience a glimpse into the future. "We live in a fast moving age", said Dr. McGugan, "with horizons ever moving".

It is not hard to conceive that under such a broad title as new horizons. "Atomic Energy in Medicine" would have a prominent place. This topic was ably presented by Dr. R. Edward Bell, director of clinical laboratory services, University of Alberta Hospital, Edmonton. Since this is such a new field in the diagnoses and treatment of disease, Dr. Bell explained that use of radio-active isotopes is strictly controlled by the Department of National Health and Welfare, Ottawa, and by Atomic Energy of Canada. As yet only a few hospitals would have adequate facilities for such treatment. Dr. Bell described, by means of charts, some of the uses of radio-active isotopes and pointed out some of the research areas where work was being done with them.

Alcoholism was described by J. George Strachan, executive director, The Alcoholism Foundation of Alberta, Edmonton, as one of the major health problems of today. Indeed, he said, it has only been within the past few years that it has been recognized as a disease. He claimed that the present-day attitude toward this illness was archaic. Since people were often afraid to seek treatment because of the stigma attached to the disease, Mr. Strachan emphasized that the prime purpose of administration in these cases was to try and change the attitude of the staff and community toward the treatment of alcoholics. He continued by saying that a nurse with the right approach to the patient could accomplish as much as any treatment procedure. Teamwork is of vital importance. Mr. Strachan told his audience that there were 140,000 problem drinkers in Canada and that only a small percentage needed to be hospitalized.

Rehabilitation was another of the newer concepts of hospital care which received attention on the institute program. Dr. J. Smith Gardner, D.V.A. surgical consultant, Calgary, Alta., spoke with enthusiasm about the "changing attitude toward cripples". Down through the ages, he said, cripples have been set apart always supported by having things handed out to them. Now the attitude has changed to the theory that they must be taught to help themselves. If this is accomplished, these patients will be rehabilitated back to a useful place in society. Dr. Gardner showed slides to illustrate how several seriously injured patients had been rehabilitated through a process which was detailed to take into consideration the physical, physiological, emotional, vocational, and economic aspects of the patient's life. Through an adequate program of rehabilitation, the patient's residual abilities are directed toward appropriate training for job placement. Dr. Gardner emphasized that "employment dispells frustration".

How the aging population changes hospitals was given factual and statistical consideration by Bernard R. Blishen, chief, institutions section, Dominion Bureau of Statistics, Ottawa. Stating that, with the growth of preventive medicine, the proportion of the older age group was increasing, he quoted statistics which showed that in 1901 the percentage of the population aged 60 and over was 7.7, while in 1951 it was 11.4. This changing picture brings about an increased emphasis on hospital accommodation for the older age group without the great need for intense active treatment care.

A Clean Hospital

Rev. Sister B. Bezaire, superior, Edmonton General Hospital, Edmonton, presided over a lively session on the mechanics of a clean hospital. This session was devoted mainly to skits and practical demonstrations of equipment which showed how to do the job well.

A skit entitled "Getting People to do It" featured Ruth Crawford, executive housekeeper, Calgary General Hospital, Calgary, and Mrs. Jeane Welsh, executive housekeeper, Holy Cross Hospital, Calgary, in the leading roles. Miss Crawford acted as the advisor, while Mrs. Welsh played the part of the inquirer. Through this excellent presentation the audience gleaned many helpful hints on how to run an efficient housekeeping department.

Miss Crawford stressed the point that a housekeeping department was only as efficient as the staff which ran it and that the staff must be ever vigilant to keep abreast of up-to-date ideas. The housekeeping department was responsible for all cleaning in the hospital except that which was directly connected with patient care—this being the responsibility of the nursing department. Wastage is a very important problem which the housekeeper must ever watch. When asked to whom the housekeeper was responsible, Miss Crawford replied that she responsible to the administrator. The housekeeper must look after hiring her own employees and she must take care to screen applications and check references if she wants an efficient and happy staff. Orientation of the new employee saves time and gives the new employee more support. Miss Crawford stressed the fact that there must be continuous vigilance for safety and she showed her audience posters which were used in her hospital to remind employees not to take chances.

Nora L. Hawkins, executive housekeeper, University of Alberta Hospital, Edmonton, then joined Miss Crawford on the platform and took part in a practical demonstration of types of equipment best suited for a variety of housecleaning jobs. Suggestions were also given on how to handle the equipment and clean it after use. Miss Crawford cautioned that each piece of equipment has a certain life span and if handled poorly the span is greatly reduced.

Much to the amusement of the audience an itinerant salesman from Ottawa, H. Gordon Hughes, appeared on the stage and tried to high pressure Miss Crawford into buying products which he had for sale. However, Miss Crawford showed how the housekeeper must buy with caution in order to get the best materials available. By this demonstration she showed her audience how not to be "taken in".

Later in the program H. Gordon Hughes, assumed his real life role as chief of hospital design division,

(Continued on page 62)

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Students in Hospital Administration at the University of Toronto

Shown on the steps of the School of Hygiene at the University of Toronto are members of the 1954-55 class in hospital administration. Having completed the academic year of the post-graduate course, they are spending administrative residencies at various hospitals in Canada and the United States.

In the back row, from the left: Dr. Robert F. Ingram who is taking his residency under the preceptorship of Dr. J. Gilbert Turner, executive director, Royal Victoria Hospital, Montreal; Albert L. Nantel takes his residency under J. H. Roy, superintendent of Hôpital Saint-Luc, Montreal; Jack R. Hagerman is administrative resident at the Toronto Western Hospital, under the preceptorship of A. J. Swanson, superintendent; Donald L. Laughlin, who is taking his residency at the Pennsylvania Hospital, in Philadelphia, Pa., under H. Robert Cathcart, administrator; Luigi A. Quaglia is administrative resident at St. Boniface Hospital in St. Boniface, Man., under the preceptorship of Sister Gertrude Jarbeau; and Dr. David M. Hall, whose appointment has been delayed.

In the middle row, from the left: George J. Riesz, taking his residency at the New Mount Sinai Hospital in Toronto, under Sidney Liswood, administrator; Sydney J. Parsons, administrative residency at Toronto East General Hospital, under W. E. Leonard, superintendent; Anita Soni, appointment delayed; Alfred S. Zukon, administrative residency at Fitkin Memorial Hospital in Neptune, N.J., under David V. Carter; Robert J. Cameron, administrative residency at Kitchener-Waterloo Hospital in Kitchener, Ont., under Walter Hatch.

In the front row, from the left: Dr. W. Douglas Piercey, assistant professor; Eugenie M. Stuart, associate professor; Dr. G. Harvey Agnew, professor; and Donald M. MacIntyre, assistant professor.

Western Canada Institute

(Continued from page 60)

Department of National Health and Welfare, Ottawa, and gave an informative and practical address on the different types of flooring which are now on the market for use in institutions. The variety of samples which he passed out to the students not only indicated the numerous varieties of flooring available but gave each and every one a chance to see and feel them.

"Does the Small Hospital Need Housekeeping?" was a question which was given consideration by Sister M. Leonard, secretary-treasurer, St. Anne's Hospital, Hardisty, Alta. Sister Leonard stated that no department could function without housekeeping. In the small hospital the housekeeper is the matron, she said. An opinion expressed by Sister Leonard was that the housekeeping personnel in a hospital should be in uniform. This, she felt, made them feel more a part of the over-all organization.

Better Food Service

Introducing a whole day's session on "Better Food Service makes for Happier Patients and Staff", the chairman Dr. D. R. Easton, superintendent, Royal Alexandra Hospital, Edmonton, claimed that patients talk about food—hot food and good coffee.

"Nutrition is the science of feeding people and dietitians carry out its principles," stated Mrs. Isola Robinson, dietetic specialist, American Hospital Association, Chicago, Ill. She urged better organization of the dietary service with the definite purpose of promoting good patient care. Since representatives of small hospitals were in the majority, Mrs. Robinson directed many of her remarks to the administrators who did not have full-time dietitians. She outlined the basic objective of the dietary department as being to serve good food which is nutritionally adequate. If it looks good and tastes good, it is eaten. She warned that time should be taken to

(Continued on page 64)

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Western Canada Institute

(Continued from page 62)

set basic policies. Ask yourself these questions. Who is to be fed? Is there sufficient space, equipment, and personnel? Who is to deliver the food? Are there basic personnel policies? Mrs. Robinson mentioned that the trend toward diet today is more simple and that therapeutic diets are as near the normal as possible. She warned that food waste was the result of over-purchasing and over-production.

"Purchasing, storing, issuing, accounting, and budgeting" came under review by Margaret G. Lang, director of dietetics, University of Alberta Hospital, Edmonton. Miss Lang stated that in a large hospital both the dietitian and the purchasing agent shared in the purchasing of food supplies; while in the small hospital this responsibility had to be assumed by the administrator. She gave many practical suggestions for choosing food and thoroughly covered the types of grading which are in current use. "Remember you get what you pay for", Miss Lang reminded her listeners. Regarding stores, she issued a warning to make certain that what is delivered tallies with the item on invoice. Miss Lang thought issuing in the small hospital was of minimal concern. Day-to-day records must be kept for accounting purposes and budgeting had to be based on two to three years' statistics.

"Hospitals can't get away with poor food," stated H. Gordon Hughes, as he explained how a better layout means better food. A flow of work which requires a minimum of steps is good planning. Decide what units should be close to one another for a minimum of cross traffic. This improves the efficiency of the staff and cuts down breakage. Mr. Hughes was of the opinion that a grade location was best for the dietary department. He discussed the advantages and disadvantages of the different types of food service systems and said that choice of a system was determined by the shape of the hospital.

Discussing recent trends in kitchen equipment, Margaret Ketchen, director of nutrition, Toronto General Hospital, Toronto, Ont., thought it was a significant trend that kitchens are being planned today as a first consideration and not as the last thing to go into the planning of a hospital. Miss Ketchen said that a kitchen should be on different types of fuel so that one service could provide meals if another was out of commission. All equipment should be purchased with the idea of saving labour and all machines must be equipped with safety devices. Miss Ketchen stated that proper kitchen equipment helps in portion control. She looked to the future kitchen as one which would be almost completely mechanized.

During the afternoon session, Mrs. Robinson discussed menu planning and thought there should be a time and place set aside for the dietitian to carry out this important task. She should make notes on what is popular and unpopular and keep a record of what has been served. Speaking on "Food Preparation, Distribution, and Storage", Miss Ketchen thought that one of the most important points here was to find out whether the nursing or dietary department was responsible for serving the food. Portion control was reviewed by Liela Taylor, dietetics department, Calgary General Hospital, Calgary. Miss Taylor stated that food costs can be cut by 20 per cent if portion control is put into practice. Under the direction of Helen Jacobson, director of dietary service, Calgary General Hospital, Calgary, a clinic was held on the use and handling of raw foods. To this demonstration was brought a large carcass of beef and expert butchers proceeded to show the audience how meat should be cut and prepared.

The Nursing Service

Friday morning was devoted to a discussion of the key hospital function —nursing service—under the chairmanship of Elizabeth A. Bietsch, director of nursing, Medicine Hat General Hospital, Medicine Hat, Alta.

The provision of *continuous* nursing care for the patient was enumerated as the most important basic principle of nursing service, by Edith Young, director of nursing, Ottawa Civic Hospital, Ottawa. The nurse of today needs sound preparation in administrative practices, she said. Today's nurse is faced with many new problems. Early ambulation requires more care because of the rapid turnover of patients, clerical work is increasing, and the nurse must familiarize herself with many more new drugs. For efficiency, Miss Young thought that the nursing unit should not exceed 30 beds and should be provided with equipment to save the nurses' time. The total number of personnel required to staff a unit should be determined by the average occupancy not the peak load, she stated. Extra personnel should be brought in to cover emergencies. Miss Young was of the opinion that the ratio of professional nurses to auxiliary nursing personnel could be decreased if professional nurses have better training, auxiliary personnel were better prepared, in-service programs were adequate, and if personnel policies were improved.

Standards for ward service were reviewed by Jeanie S. Clark, director of nursing, University of Alberta Hospital, Edmonton. Miss Clark considered that the first step in setting standards was to make a nursing service plan and then modify it to fit the particular situation. The intelligent allocation of staff is only possible if there is a plan. Techniques of procedures must be given careful consideration, according to Miss Clark. She also thought that a centrally located nursing station and a quiet room where the head nurse could think and plan were necessary standards for good ward service. Over-all planning for the ward should be considered on a yearly basis and then be broken down into weekly and daily plans.

Katherine Macalister, matron, Red Deer Municipal Hospital, Red Deer, Alta., discussed nursing service problems in the smaller hospital. Miss Macalister's idea of a small hospital was one of 100 beds or under. In her opinion greater versatility and flexibility were required of the nurse in the small hospital. Here, a nurse must have a basic idea of all services. She must also teach the non-professional personnel. Miss Macalister stated that it was not practical to have heads of departments in a small hospital. The use of ward clerks was discussed and it was pointed out that a person chosen to take over these duties would have to be selected with care. In a small community the ward clerk would probably know most of the patients and she would have to be trusted not to divulge any professional information.

Edith Young spoke again later in the morning on budgeting for nursing service. She stated that the nursing director must make out the budget and she must know the financial situation of the hospital. There should be sep-

(Concluded on page 66)

Coming Conventions

Aug. 13-14—Institute on Hospital Pharmacy, Vancouver, B.C.

Aug. 15—Annual Meeting of the Canadian Society of Hospital Pharmacists, Vancouver, B.C.

Aug. 24-25—Maritime Conference of the Catholic Hospital Association, Moncton, N.B.

Sept. 7-10—Annual Meeting of the Canadian Society of Radiological Technicians, Windsor Hotel, Montreal, P.Q.

Sept. 14-15—Catholic Hospital Conference of Alberta, Harris Sky Rooms, Calgary.

Sept. 17-19—Annual Meeting of the American College of Hospital Administrators, Traymore Hotel, Atlantic City, N.J.

Sept. 19-22—Annual Meeting of the American Association of Hospital Consultants, Atlantic City, N.J.

Sept. 19-22—American Hospital Association Convention, Atlantic City Convention Hall, Atlantic City, N.J.

Sept. 27-29—Annual Meeting of the Canadian Association of Medical Record Librarians, Halifax, N.S.

Oct. 9-10—Catholic Hospital Conference of British Columbia, St. Vincent's Hospital, Vancouver.

Oct. 11-14—British Columbia Hospitals' Association Convention, Vancouver.

Oct. 18-20—Annual Meeting of the Associated Hospitals of Manitoba, Winnipeg, Man.

Oct. 23—Annual meeting of the Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 24-26—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Annual Meeting of the Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask.

Oct. 27-28—Annual Meeting of the Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto.

Oct. 29-31—Annual Meeting of the Canadian Association of Occupational Therapy, Toronto, Ont.

Western Canada Institute

(Concluded from page 64)

arate budgets for each department. If there is a clear line of responsibility, she said, there should be no overlapping of services. Miss Young thought the budget should be prepared according to the hospital's fiscal year. She also emphasized the fact that budgeting was needed as much in small hospitals as in the larger ones.

Public Relations

"Public relations made easy" was the subject of the final session of the institute. Presided over by S. V. Pryce, business manager, Holy Cross Hospital, Calgary, Alta., a workshop was held by a panel of public relations experts from the oil industry.

Achieving good public relations doesn't just happen, it is brought about, claimed Don Reed of the Canadian Petroleum Association, Calgary. Mr. Reed convinced his audience that public relations was a science—an art—and not a high powered attempt to deceive by flattery. Some people think public relations is an expensive luxury but the speaker pointed out that it is the third dimension in business. H. Reg. Hammond, Royalite Oil Co. Ltd., Calgary, gave a picture of how the press and radio fit into the over-all public relations program. One of the most important points in giving out news to the press and radio was to have an information officer who knows how to prepare and give out information.

How public relations can fit into personnel administration was given consideration by John S. McAlister, Sun Oil Company, Calgary. People recognize a happy employee, he stated. An employer has to sell himself to an applicant because an applicant can be a boaster or knocker for that business. Jack S. Peach, Canadian Petroleum Association, Calgary, had some helpful hints on how to interest the community in an organization. He suggested that the teachers in a community should be made aware of the functions of a hospital for they, in turn, will pass this information on to their pupils. Any public relations program depends on "selling yourself the idea first" then you can convince your listeners. Mr. Peach emphasized the need to be alert as "there is always a better way of doing things".

Informality for All

On the lighter side, students and faculty members met together informally in the evenings and here the exchange of ideas and the discussion of mutual problems was of benefit to all. Newcomers to Edmonton also had the opportunity to tour the city and surrounding district. Specialized hospital tours were arranged for one afternoon of the institute. The 1955 institute closed on Friday afternoon when the students left to return to their hospitals, having gleaned added knowledge of hospital affairs from the well-planned program. In the fall of 1956, Vancouver will play host to the eleventh Western Canada Institute for Hospital Administrators and Trustees.

Palestine Refugees Receive Nursing Certificates

Thirty-four young Palestine refugees received their general nursing certificates from the Jordan Health Minister at Jerusalem's Augusta Victoria Hospital recently. Their graduation came after three years of training through a joint program of the Jordan Government, the Lutheran World Federation and the UN Relief and Works Agency for Palestine Refugees (UNRWA). One hundred and thirteen nurses are expected to be trained.

The newly graduated nurses have already found jobs in Jordan and other Arab countries. Seven will be working with UNRWA's health division now offering free medical services to more than 880,000 Arab refugees, while the others will join the Jordan Government and private hospitals where there is a shortage of qualified nurses.

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With the Auxiliaries

President of Alberta Auxiliaries Reports

(The following is from a report presented to the 12th annual convention of the Associated Hospitals of Alberta, by Mrs. E. Wershof, president of the Associated Auxiliaries of Hospitals of Alberta.)

DURING THE seven years of existence of the Associated Auxiliaries of Hospitals of Alberta, 50 auxiliaries have been formed with a total membership of over 1,000. The program has been divided more or less into two categories — service to hospital patients and nurses, and financial contributions. The extent of the financial contribution has been tremendous, especially when we realize that this money, particularly in the smaller areas, has been raised primarily through home-cooking sales and teas.

Hospital auxiliaries are playing an increasingly important role in communities today. It is now being recognized that with the ever-increasing cost of operating a hospital, the moral and financial support of a women's auxiliary is of vital importance to the hospital and town. Thus you find that the hospital auxiliary is supplying anything and everything from bedroom slippers and books, to radios, hospital equipment and furnishings. The list is never ending and includes microscopes, operating lamps, and resuscitators. Each auxiliary caters to the needs of its own hospital.

Besides the actual financial support, the members of auxiliaries also try to provide extra services for the hospital staff and patients. It is realized that nursing staff may be lonesome away from home and that there may not be much for them to do in their leisure hours, especially in the smaller centres. Thus many of the auxiliaries try to make life a little more pleasant for the nurses by having various social contacts with them. Work with the patients is varied according to special needs. Most auxiliaries have a system of visiting patients and providing treats for them on special occasions. Some groups provide books and magazines, as well as car services. A few even teach handicrafts. In each auxiliary, the members are always on the lookout for ideas to try and make life a little more pleasant for the patients. Still others do all the necessary sewing and such services as the hospital may request. And, of course, the importance of public relations is stressed in the hospital auxiliary program.

Last year, we affiliated with the National Council of Women's Hospital Auxiliaries of Canada. It was felt that we would thus have a stronger and more secure basis. We agreed with the national leaders that, while not neglecting our own community work, we should broaden our horizons and concern ourselves not only with the health and welfare problems in our own communities but across Canada and indeed throughout the world.

* * * *

Auxiliary Active at Vernon Jubilee Hospital, Vernon, B.C.

This year the women's auxiliary to the Vernon Jubilee Hospital, Vernon, B.C. have already purchased an ice-cube maker, a walker, and two electric dish warmers. In March the auxiliary held their annual fashion show, which was highly successful. The auxiliary sponsored "Hospital Day" on May 28th. On this occasion tea was served on the lawn and a sale of home cooking and other articles was held. A further project which the auxiliary has accepted for the year is the purchase of a blood bank refrigerator.

* * * *

Auxiliary Furnishes Ward

A cheque for $1,603, covering the entire cost of refurnishing the maternity ward of the Listowel Memorial Hospital, Listowel, Ont., has been given to the hospital's board of trustees by the women's auxiliary. The ladies are making plans already for their annual fall fair and will have a draw again this year, with first prize being a bedroom suite.

New officers of the Maritime Hospital Aids Association elected at their annual convention held in Charlottetown, P.E.I. last month are: Front row, left to right: Mrs. P. J. Connolly, Sydney, N.S., 1st vice-president; Mrs. R. MacPhee, Glace Bay, N.S., recording secretary; Mrs. Gordon Leitch, Charlottetown, president; Mrs. B. L. Moran, Chatham, N.B., past president; Zita Garnier, North Sydney, N.S., treasurer.

Back row, from the left: Mrs. H. A. MacQuarrie, Westville, N.S., liaison officer; Mrs. Roy Ellison, Millstream, N.B., zone chairman; Mrs. T. J. Holland, Halifax, N.S., zone chairman; Mrs. A. M. Hunter, Halifax, 2nd vice-president; Mrs. D. J. Eastham, Saint John, N.B., 3rd vice-president; Mrs. Frank McCarron, Southport, P.E.I., 4th vice-president; Mrs. Clifford Sherren, Alexandra, P.E.I., zone chairman; Margaret McCormack, North Sydney, N.S., zone chairman. (Photo, Barter's Film Lab., Charlottetown.)

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◀ Provincial Notes ▶

Yukon

WHITEHORSE. Plans are being laid by architects Rule, Win and Rule of Edmonton for the new $3,000,000 120-bed hospital which will perch on the bench-land across the Yukon River from Lambert Street. The hospital will be in the shape of an H, with the entrance on the west side. None of the wards will contain more than four beds, and two-bed rooms will be available. Modern equipment and facilities will include two elevators, three doctors' offices, examining rooms, a lecture-demonstration room, a snack bar and concession stand, visitors' rooms, and children's playrooms, and the architecture will permit further future additions. Various residences, a heating plant, and a laundry and garage building will complement the main structure.

The hospital will be operated under the Department of National Health and Welfare's northern health services branch. All employees will be civil servants and the hospital will be used jointly by the armed services, Indian Affairs department, and by Yukon residents generally.

British Columbia

ESSONDALE. High winds and low pressure in the hoses were blamed for the $500,000 fire which destroyed a four-wing, three-storey building at the Provincial Mental Hospital early in May. Hospital officials said the damage would be about half a million dollars, for the building contained the latest in therapeutic equipment. Eight professionals and 20 volunteer firemen fought the blaze, and one firefighter was overcome by smoke. There were no other injuries.

* * * *

Early in May, the new 250-bed North Lawn hospital unit for the treatment of tuberculosis and other infectious diseases among Essondale's 6,500 mentally ill patients was officially opened by provincial government officials. The unit was constructed by the firm of A. F. Kennett.

LAKE COWICHAN. Preliminary plans for a 50-bed hospital here will be drawn by the firm of Gardiner & Thornton, Vancouver, preparatory to construction. The hospital will serve Lake Cowichan, Youbou, Mesachie Lake, Honeymoon Bay and Caycuse.

* * * *

VANCOUVER. The $1,000,000 addition to the nurses' home and surgery department of St. Paul's Hospital was completed recently. The six-floor addition will contain 87 units for nurses, with classrooms, an auditorium, dining-room and coffee shop. The top floor will house an operating room, and the hospital's main kitchen will be located on the ground floor.

* * * *

VANCOUVER. At an estimated cost of $594,136, 62 beds will be added to the 100-bed Mount St. Joseph's Hospital within the next year.

* * * *

VANCOUVER. The contract has been awarded for construction of the new $226,000 United Church Queen Charlotte Islands Hospital, which will serve all the various islands in the Queen Charlotte group. The interior walls will be hard-plastered, the exterior stucco. To give the islands proper medical care, the hospital administration is also backing the building of the Masset-Port Clements road. In the meantime, the old hospital is being used, but the number of patients is increasing each month.

Alberta

BARRHEAD. It is expected that the new 60-bed St. Joseph's Hospital will open in late summer. Landscapping of the grounds and stucco work on the exterior are now under way.

* * * *

CARDSTON. With the trade-in of the old unit, an x-ray machine, with all the up-to-date features considered important for work likely to be undertaken now or in the future, has been purchased for the Cardston Municipal Hospital for $3,500. The new equipment is a two-tube unit which will have double the power and twice the speed of exposures. In addition, by the "spot film device" attached to the new fluoroscopic screen, doctors can snap a picture of what they are seeing at any moment during the fluoroscopy.

* * * *

EDMONTON. The Royal Alexandra Hospital will receive a $23,580 grant from the provincial and federal governments for the provision of six additional beds and out-patient facilities.

Saskatchewan

ESTEVAN. Construction has begun on the 25-bed addition to St. Joseph's Hospital here. The addition is being made at the south end of the present building.

* * * *

HUMBOLDT. The cheque for $2,000 that was presented by the Humboldt Lions Club to the new St. Elizabeth Hospital is to be used for furnishing a children's ward. Money for the project was raised through the Lions Club car raffles in connection with the annual agricultural fair.

* * * *

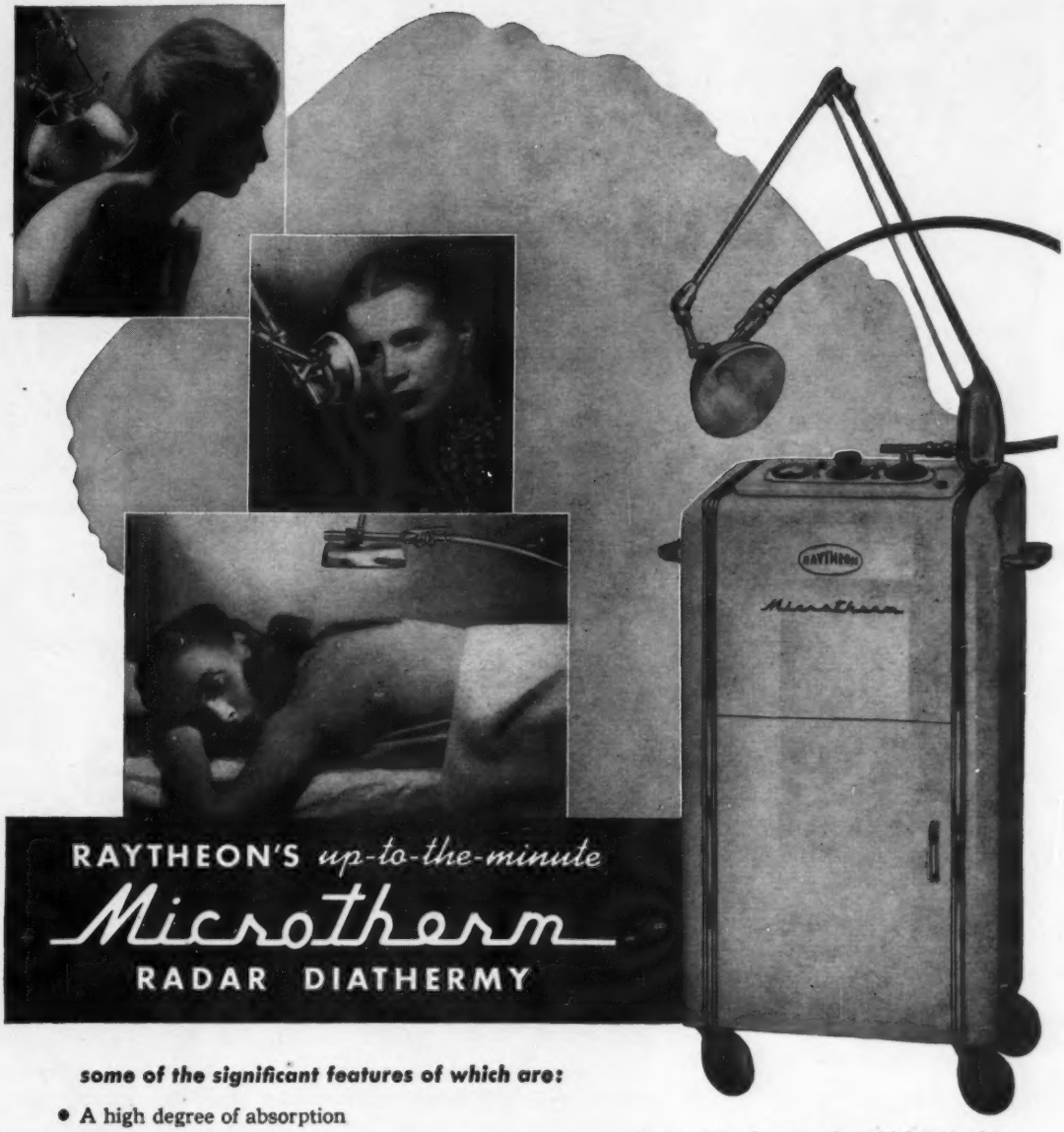
SASKATOON. Operational costs of the Saskatoon City Hospital were reported as $53,656 higher for the first quarter of this year than in the corresponding period of 1954. The discrepancy is attributed to a $47,956 increase in expenses, and a $5,700 decrease in revenue.

* * * *

URANIUM CITY. All patients were evacuated safely when fire destroyed the seven-bed Uranium City Hospital early in May. The hospital, one of the three in the Uranium City area, 450 miles northwest of Prince Albert, was valued at $50,000. It was financed by the Beaverlodge local development area and staffed by the department of public health.

Manitoba

BRANDON. A $140,000 addition to the Brandon General Hospital, where-



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by the capacity will be raised from 148 beds to 204 beds, has been approved. Funds will be raised by public subscription.

* * * *

PORTAGE LA PRAIRIE. The tender of $455,207 advanced by the Heath Construction Co. of Winnipeg and Moose Jaw for the construction of a new 100-bed hospital has been accepted by the directors of the Portage la Prairie and district hospital board. The building will not be ready for occupancy until next summer.

* * * *

WINNIPEG. The $5,500,000, eight-storey addition to St. Boniface Hospital was officially opened early in May. With an increased capacity of 467 beds, the hospital, run by the Grey Nuns of the Sisters of Charity of Montreal, is now one of the largest and most modern in Canada.

* * * *

WINNIPEG. Construction of Winnipeg's new $3,000,000 Children's Hospital was officially launched, recently, when Governor-General Massey declared the corner-stone "well and truly laid".

* * * *

WINNIPEG. A seven-storey addition to D.V.A. Deer Lodge Hospital will be constructed as soon as contracts have been awarded. The new wing will replace the present wooden temporary structures behind the hospital and will accommodate approximately 300 beds. It will also contain new modern operating rooms, x-ray facilities and laboratories, and will be connected to the third floor of the hospital, to the pavilion, and the unit which at present houses the kitchens and other hospital facilities.

Ontario

BRUCE MINES. Preparatory to the foundation of a $30,000 emergency hospital on the site of the former Algoma Co-operative Creamery, rock drilling has begun. The hospital is being built by Dr. Lawrence R. Hill, MOH for Bruce Mines and Plummer Additional Twp. It will be the only hospital equipped to handle medical emergencies between Thessalon and Sault Ste. Marie, and also St. Joseph Island. Architectural plans, prepared by John B, Parkin, Toronto, allow for future expansion.

CORNWALL. Coinciding with the increasing tempo of the construction work on the new St. Lawrence power project, a modern, two-storey, two-wing, 30-bed hospital with most of the facilities of a large institution will be opened two miles west of Cornwall. The hospital will help to relieve the load on local facilities imposed by the influx into the area of a large number of workers. Its staff will include a resident medical officer, registered nurses, first aid ambulance men, a housekeeper and assistant, and a secretary. Plans were prepared by Kenneth H. Candy, architect.

* * * *

LONDON. The eight-storey, 550-bed, $4,027,000 addition to Victoria Hospital was officially opened on Hospital Day in May. Renovations in the older building, undertaken by a London firm for $73,000, include the construction of two delivery rooms and seven labour waiting rooms which will be added to the maternity ward. Although this will entail a four-month halt in operations for portions of the fourth-floor ward, temporary facilities will be provided in the new "Y"-shaped wing of the hospital.

* * * *

MOUNT FOREST. New hospital equipment and furnishings valued at $4,990, will be purchased for the Louise Marshall Hospital.

* * * *

NORTH BAY. Work has begun on seven of the nine buildings to be constructed at the Ontario Hospital site five miles north of the city at Cook Mills. Each pavilion in this 1,100-bed project will be 320 feet long and 65 feet wide and will have accommodation for 180 patients. The nurses' residence will be five storeys high.

* * * *

PORT ARTHUR. Construction of a 110-bed residence for nursing students at St. Joseph's Hospital will likely be completed this month. The four-storey building, located immediately behind the hospital, will provide complete training facilities and living accommodation for 108 nurses, as well as the matron and director. The three upper storeys, of the T-shaped building will be devoted entirely to living accommodation. Each of the upper storeys will include 26 single rooms and five double rooms. The basement, which is constructed on two levels, will have a combination auditorium and gymnasium on the lower level, with training facilities on the higher level. Each floor is serviced by an elevator and four stairways.

* * * *

SUDBURY. The new mental health clinic, which enlarges the Sudbury General Hospital of the Immaculate Heart of Mary to a capacity of nearly 350 beds, was officially opened early in May. Special praise was advanced toward Dr. T. P. Dixon, head of the new unit, and toward the Sisters of St. Joseph, for their invaluable services to the community.

* * * *

THORNHILL. A new two-million dollar community hospital is planned for a 14-acre site at the corner of John Street and Bayview Avenue. This 150-bed institution is to serve a wide area extending from North Toronto through the townships of North York, Markham and Vaughan, and including the village of Richmond Hill.

* * * *

TORONTO. The will of Barney Joseph who died March 16 revealed a $25,000 bequest to the New Mount Sinai Hospital for the establishment of a fellowship for medical research. The bequest is to be paid to the individual to whom the fellowship is awarded by the medical board.

* * * *

WALKERTON. Plans for the new three-storey (75′ by 45′ by 35′) addition to the County of Bruce General Hospital have been approved. The wing will be constructed west of the northwest wing of the present building, under the guidance of the Toronto firm of architects, Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside. Presently under construction is a new ambulance entrance to the elevator.

Quebec

MONTREAL. A "mechanical brain" which consists of a tabulator, sorting machine, reproducer and a collator, has been installed in the Royal Victoria Hospital. The tabulator can provide statistics on administration and professional care and can do

(Concluded on page 96)

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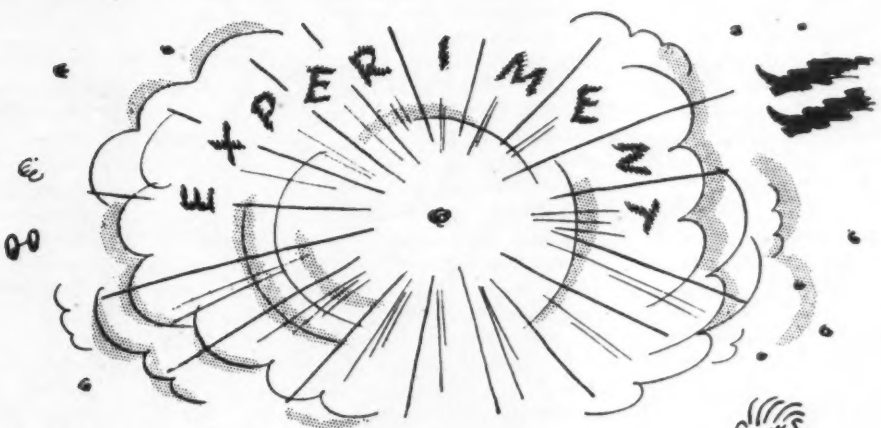

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Book Reviews

PATTERNS OF PATIENT CARE. Some studies of the Utilization of Nursing Service Personnel. By Frances L. George, R.N., M.A., professor of nursing education, University of Pittsburgh, Pittsburgh, Pa.; and Ruth P. Kuehn, R.N., Ph.D., professor of nursing education, and dean of the school of nursing at the University of Pittsburgh. Edited by Josephine Nelson. Pp. 266. Illustrated. Price, $4.50. Canadian agents, the Macmillan Company of Canada, Limited, Toronto.

This is a report of studies conducted by the University of Pittsburgh School of Nursing, under a grant from the Sarah Mellon Scaife Foundation. As such, it seeks to answer the question of how much nursing service is required by a group of non-segregated medical and surgical patients in a large general hospital. An analysis is made of the functions which can safely be delegated to non-professional personnel, *i.e.*, the ward clerk and the nurses' aide. An important part of the study is the staffing pattern which the research team has devised to assure a fair distribution of personnel to various tours of duty and permits pre-planning of days off duty.

In their summary, the authors point out that "when new patterns in ward management have been established and a sufficient number of hours of nursing service have been made available . . . then patients will receive the kind and amount of nursing care required to carry forward the diagnostic, therapeutic, and rehabilitative plan prescribed by the physician". They go on to emphasize the preventive aspect of modern hospital care, with health instruction being provided for the family as well as the patient in the future. They conclude with the thought that the way ahead for nursing is full of challenge and also of promise.

Complete with appendices, outlining basic nursing activities, procedures allocated to non-professional staff, personnel policies for ward clerks, and other pertinent information, *Patterns of Patient Care* should be of interest and value to all those concerned with providing good nursing service. The book is illustrated by many graphs and figures and has a very complete and helpful bibliography.

HOUSING THE AGED. Edited by Wilma Donahue. Pp. 275. Price, $3.75. Published by the University of Michigan Press, Ann Arbor, Michigan.

This volume is a report of the Fifth Annual Conference on Aging, which was held in Ann Arbor in 1952. Thus it is a comprehensive study of the challenges which face us today in providing proper facilities and care for our older people as set forth by well-known authorities in a variety of fields.

Perhaps one of the most important keynotes of this study is struck by Dr. Robert Monroe who introduces the section on the housing of older people who require sheltered care and medical supervision. Dr. Monroe points out that the care of the aged is not "just the prescription of pills for symptoms; it is the search for and control of all disabilities that can be found". However, most of all, says Dr. Monroe, "it is the care of the old person as a whole person". What the geriatrician needs are "physical and mental rehabilitation centers, occupational services leading to jobs, housing developments, and social outlets".

Other contributors show what can be done and is being done to provide these necessary facilities and services. A representative of the building industry discusses the specialized housing needs of the aging, from the viewpoint of the private builder. Various schemes, such as communal arrangements, are described in urban as well as rural settings. "How much will it cost and how and who will pay for it?" These perpetual questions are given due consideration, with attention being paid to various sources of capital.

The study concludes with the thought that "the job of providing housing for old people cannot be done by any single group. It will require the best talent of architects, builders, planners, economists, physicians, and those who understand the social requirements of the aging." Already, it is pointed out, there is much evidence that this difficult task has become a concern of older people themselves and of those experts and groups who can help bring about an expansion of housing facilities for them.

THRESHOLDS TO PROFESSIONAL NURSING PRACTICE. By Frances M. McKenna, R.N., M.A., Dean, School of Nursing, professor of nursing, at Baylor University, Waco, Texas. Pp. 374. Price, $4.25. Published by W. B. Saunders Company, Philadelphia, Pa.

This book has been written with a view to assisting in the adjustment of the senior student nurse, who has lived in a relatively protected and regimented environment, to her new status as a graduate nurse in an adult society. Thus the subject matter has been divided into units whose titles reveal a well-rounded content— thresholds to adult living; employment and opportunities for service; and personal obligations.

Although the book is written with reference to American organizations, and situations, there is much useful information for both Canadian student nurses and for instructresses in professional problems.

WHO and UNESCO Inventory of Equipment for Medical School

A detailed inventory of the equipment needed to set up a medical school is now available as the result of a joint undertaking by the World Health Organization and the United Nations Educational, Scientific, and Cultural Organization. This reference manual is intended chiefly for use in new medical schools. It is the latest in a series of inventories of apparatus and materials for teaching science at all levels. This series was begun by UNESCO in 1949 to promote the introduction of suitable science teaching into schools of war-damaged or undeveloped regions. The World Health Organization has been responsible for the preparation of the manuscript and for the entire technical presentation, while the publication and translation have been the responsibility of UNESCO.

The book contains lists of equipment used in the instruction of medical students in eight subjects: anatomy, bacteriology, biochemistry, histology, pathology, pharmacology, physiology, and hygiene and public health. The material listed under each subject represents the consensus of some 20 professors from different parts of the world on the equipment needed.

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Constructing Hospitals

(Concluded from page 34)

made the department excessively hot, the experiment was considered to be very successful in overcoming the unbearable and dangerous conditions that had been the cause of their complaint.

This experiment and its results indicate that, if radiation of body heat to cooler surfaces were tried, the high cost of full air-conditioning installation and operation in hospitals might not be justified. From a bacterial standpoint, the danger of spreading infection from one part of a hospital to another in the use of ordinary air-conditioning methods would be reduced and that alone would be a distinct gain.

Expansion and Contraction

Far too little attention has been paid by architects and engineers to the need for protecting structural members against expansion and contraction due to fluctuation of outdoor temperature from season to season. Daily expansion of steel columns in east, south and west walls due to sun heat has caused cracking of walls, floors, plaster, tile and terrazzo finishes, et cetera. This problem has not received sufficient attention.

Moisture Penetration

The subject of moisture penetration into and through walls was discussed very fully at the meeting of the Royal Architectural Institute of Canada, held in Montreal, June 1954. Copies of the papers given by Lorne Wiggs of Wiggs, Walford, Frost & Lindsay, Consulting Engineers, Montreal, and Neil B. Hutcheson, Research Council, Ottawa, may be obtained by application direct to the authors or by referring to the *Journal of the Royal Architectural Institute of Canada*, June 1954.*

Results of Vibration

The tremendous increase in heavy truck traffic and the movement and operation of huge vibrating equipment, and pile driving, have very greatly increased the damage which is being caused in structures located on or near highways and streets or close to new heavy construction projects. Our attention has been given to serious damage in numerous hospitals due to traffic conditions which have changed only within recent years. These possibilities should be carefully studied by all hospital boards.

Conclusion

There is abundant evidence that hospital construction and administration costs are certain to be seriously increased if hospital boards and architects do not give particular attention to Canadian climatic, economic, and social factors which differ materially from those in other countries.

**My own contribution at that meeting was printed in the same journal, November, 1954 and a copy of the reprint can be obtained by writing to me, 10 Price Street, Toronto 5.—J. G.*

The Wisdom of the Ancients

The Palace of Minos, at Knossus, dating from about 2,000 B.C., possessed a system of drainage, Ninevah had its sewers more than 3,000 years ago and, about 588 B.C., the Cloaca Maxima of ancient Rome was built. Nevertheless, in the modern world in general, sanitation may be considered as having originated within the past 200 years and as having been developed, uninfluenced by ancient knowledge, mostly during the past century.

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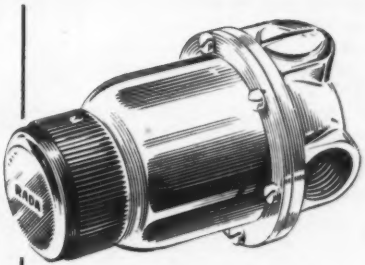

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Long before clinical signs are diagnostic of nutritional failure there may be blood or urine changes of help in diagnosis. Analyses for these changes are not always easily obtained because they are somewhat specialized. Such analyses can be done on very small volumes of serum, permitting their use with finger-prick samples.

On as little as 0.1 ml. of serum it is possible to estimate all the following: Vitamin A, Carotene, Ascorbic Acid, Alkaline Phosphatase, Total Protein. As little as 10 c.c. of urine can be tested for excretion of three B vitamins. If the body is excreting them, then they are probably adequate in the diet.

Methods for these microchemical estimations have been developing for the past decade, and the Clinical Nutrition Laboratory, Department of National Health and Welfare, Ottawa, has been using them since their inception. This laboratory is now prepared to provide certain analyses, free of charge, according to arrangements with the Provincial Laboratory in each province. This service may be made available to hospitals as well as to physicians.

Information should be obtained from the Director of Laboratories in each province. For some analyses, such as Ascorbic Acid (Vitamin C), special freezing and shipping precautions must be worked out with the Provincial Laboratory. For other nutrients, that are not heat-labile, shipment can be made in the usual specimen mailing tube. The Provincial Laboratory may authorize hospitals, and even private physicians, to ship directly to Ottawa. All samples must be accompanied by a special request form, and must be properly treated. Forms and directions are available from the Provincial Laboratory.—*L. B. Pett, Ph.D., M.D., and G.F. Ogilvie, B.A., Nutrition Division, Department of National Health and Welfare, Ottawa.*

Ontario Heart Foundation

At the annual meeting of the Ontario Heart Foundation recently, it was disclosed that, thanks to the $100,000 grant received from the Ontario Government, post-graduate courses on heart disease will be given by specialists in centres—including the universities—throughout the province. Public health grants, under the national health program, will provide $99,000 for the study of several aspects of the heart problem at the various university centres throughout Ontario. It was reported that a combined medical-surgical cardiovascular research unit, financed largely by a yearly block grant which will provide uninterrupted support of major research projects, directed by full-time investigators, had been established at the Toronto General Hospital.

Sesame

Sesame seeds add a nut-like texture to salad dressings. A sesame seed dressing is especially delicious when used on a chef's salad or Salade Maison. The seeds are added just before the salad is tossed. Two tablespoons per pint of dressing is about the right amount.—*Institutions.*

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Hospital Construction in Britain

Proposed hospital building schemes for England and Wales were outlined in the House of Commons recently by the Minister of Health, the Rt. Hon. Iain Macleod. The building program, he said, will be expanded in two ways: first, by beginning new major building projects, including new hospitals; and secondly, by a special allocation of money for plant replacement and redeployment program.

It was proposed, in 1956-57 and 1957-58, to start major new building projects to a total value of £7½ million and £10 million respectively. For the plant replacement and redeployment program, £2 million will be available in the first of those years and £4 million in the second. Apart from those amounts, there will be £9 million available in 1956-57 and £10 million in 1957-58 for capital expenditure on other works. It is difficult to be precise about the total annual expenditure involved in those two years, but it is expected to be about £13 million and £18 million respectively.

The first batch of major projects included: new general hospitals, or the first stages in their construction, for Welwyn, West Cumberland, West Cornwall, Harlow, and Swindon; the development of the Glangwili Hospital, Carmarthen; a new mental hospital near Wolverhampton; major extensions at mental deficiency hospitals in the Newcastle, Sheffield and Liverpool regions and in Wales; new out-patient department at the Royal Victoria Infirmary, Newcastle, the Leeds General Infirmary, and the Lewisham and North Middlesex Hospitals; a new block at St. James's Hospital, Balham; and major extensions to the Peterborough Memorial Hospital. Considerable expenditures are likely to be needed during the period for making good structural defects at the Manchester Royal Infirmary.

There will also be many other projects to be considered for inclusion. Among these, to start within the next few years, are the new Cardiff teaching hospital, the rebuilding of Charing Cross Hospital at Harrow, a new ward block at Guy's Hospital, new general hospitals at Slough, Boston in Lincolnshire, Coventry, and Sheffield, and new mental hospitals in Lancashire, and Yorkshire.

A statement about hospital building in Scotland was made by the Joint Under-Secretary of State for Scotland, Cdr. T. D. Galbraith. The total provision for hospital building in Scotland, he said, will be increased from its present level of £1,900,000 this year and next, to £2,200,000 in 1956-57 and £2,500,000 in 1957-58. Of the additional funds thus made available, £50,000 in 1956-57 and £150,000 in 1957-58 will be used to supplement the present special program of plant renewal, on which £80,000 altogether will be spent in the three years from 1955-56 to 1957-58. The balance will be used to increase the number of major building schemes undertaken and he expects that it will be possible to put in hand schemes to a total value of £3 million

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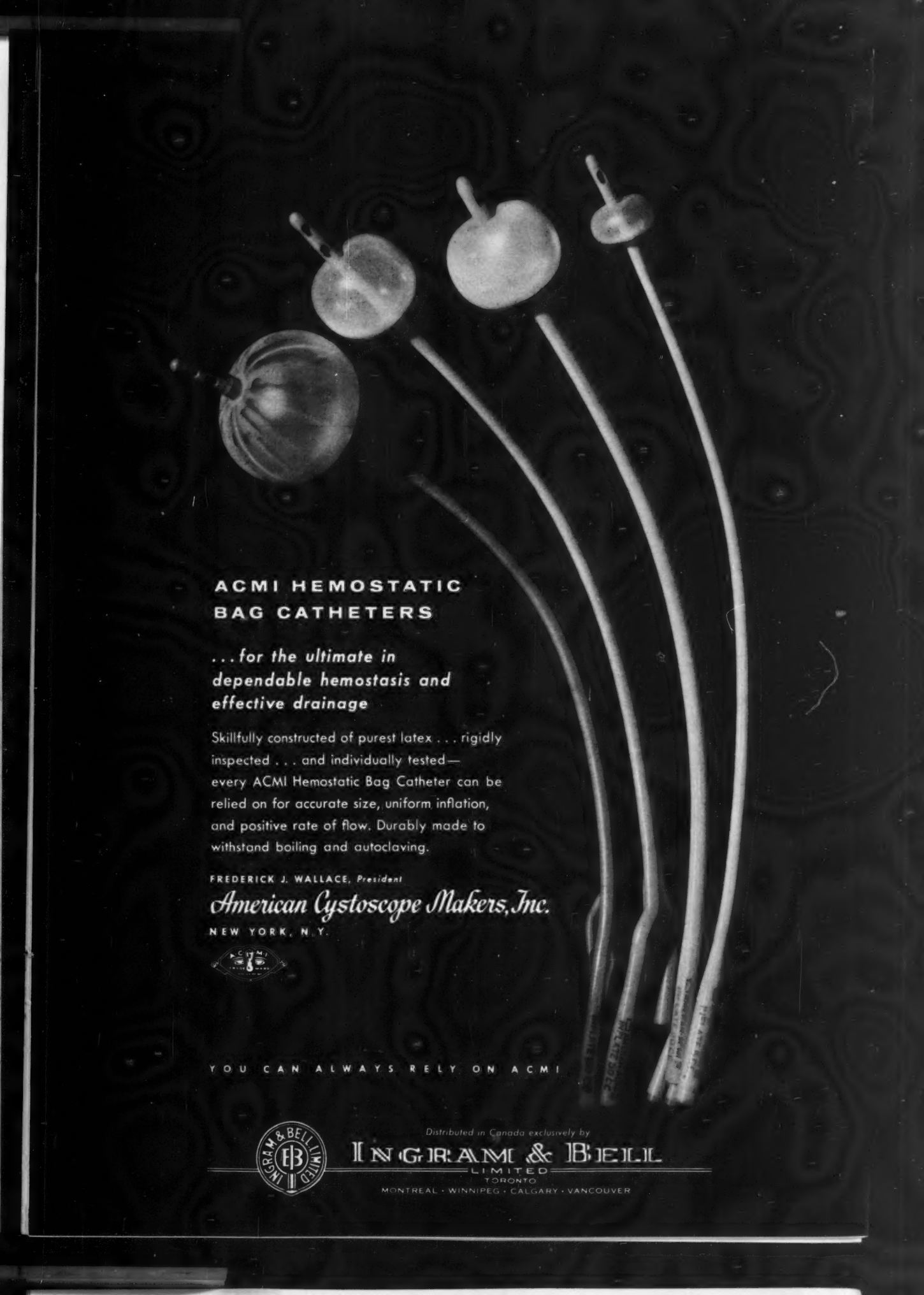

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Construction in Britain

(Concluded from page 84)

during those three years. In 1955-56, a start will be made on a new maternity hospital at Bellshill, Lanarkshire, a new surgical block at Kirkaldy, and the reconstruction of a mental hospital in Dundee.

Among projects to be considered are extensions to mental deficiency institutions in Banff and the Glasgow area, a new treatment unit at Glasgow Western Infirmary, reconstruction of the Edinburgh Royal Mental Hospital, and improvement of hospital facilities in Shetland. Detailed planning work will also be put in hand for other schemes to start in 1958-59 and succeeding years, including the provision of a complete new teaching hospital in Dundee.—*A. Whiteman.*

Hospital Pharmacists Will Hold First Institute in Vancouver

The Canadian Society of Hospital Pharmacists will hold its first institute on hospital pharmacy in Vancouver, B.C. this August. The sessions will be conducted on the campus of the University of British Columbia in Vancouver for two days prior to the Canadian Pharmaceutical Association Convention which is scheduled for August 14-17th.

A unique feature of the program is the "open forum on questions submitted by hospital administrators and hospital pharmacists". Prior to the institute, a circular is to be sent to each administrator and hospital pharmacist in Canada requesting questions which will be answered by the institute faculty and students. Papers to be presented at the institute will supply up-to-date information on topics such as: responsibilities of the hospital pharmacist in hospital organization; better relationships between the pharmacy and accounting department; problems of mixed infections; opportunities for professional advancement for hospital pharmacists; responsibilities of the hospital pharmacist in Canada's civil defence program; and the development of a practical manufacturing program in the hospital pharmacy. Workshop sessions will provide discussion on proper ward stock control; functional use of floor space; how to compile a hospital formulary; and other subjects such as the pharmacy and therapeutics committee.

Co-ordinating arrangements for the institute are Mrs. Isabel Stauffer, chairman of the committee on education of the Canadian Society of Hospital Pharmacists; Carl Forrest, president of the B.C. branch of the society; and Dale Christianson, president of the C.S.H.P.

Vitamin C in Iron-Deficiency Anaemia

More food iron can be absorbed if relatively large amounts of citrus juices are taken at the same time, it has been found in studies conducted on the nutritional factors in iron-deficiency anaemia at Washington University School of Medicine. Ascorbic acid usually increases the assimilation of food iron even more in iron-deficient than in normal subjects, states Dr. Carl V. Moore, who conducted the studies. Adding one gram of ascorbic acid to the bread eaten by six healthy subjects increased the absorption of iron two to three times.

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Maritime Hospitals Convene

(Concluded from page 55)

and outlined the importance of hospitals as educational institutions. He cautioned his audience that in this era of tremendous mechanical advances and "wonder drugs", hospitals must not forget that they are people and become so absorbed in gadgets that they forget to deal with personalities. Dr. Shaw stated that the hospital can become a friendly place if all concerned with it develop their personalities as individuals and as a group. A hospital without hospitality is not a hospital at all, said Dr. Shaw.

An official civic welcome was extended to delegates and friends of the Maritime Hospital Association on the first afternoon of the meeting. They were received at tea in the gymnasium of the Cundall Home, as guests of the senior and junior aids of the Prince Edward Island Hospital and the Charlottetown Hospital.

One evening, the Maritimes Hospital Exhibitors' Association provided excellent entertainment for the delegates, including an exhibition of square dancing and several musical numbers.

The final session of the convention was held at the Charlottetown Hotel on June 3rd. Reports of the resolution and nominating committees were presented. In addition to the usual votes of thanks, the delegates expressed their appreciation to their retiring president, R. W. Skeat and to Mrs. Gladys M. Porter, the secretary-treasurer, for the very efficient manner in which they conducted the convention.

Officers

President: R. H. Stocker, administrator, Western Memorial Hospital, Corner Brook, Newfoundland.

Past President: R. W. Skeat, business manager, Moncton Hospital, Moncton, N.B.

Vice Presidents: Nova Scotia—Dr. Hugh MacKay, New Glasgow; Prince Edward Island—Col. L. F. MacDonald, Charlottetown: New Brunswick—C. T. Ballantyne, St. Andrews; Newfoundland—Dr. E. Wilson, St. John's.

Secretary-Treasurer: Gladys M. Porter, Kentville, N.S.

Executive Members: Nova Scotia—Mayor W. D. Morton, Windsor; New Brunswick—Dr. H. S. Wright, Fredericton; Prince Edward Island—Neil D. MacLean, Charlottetown.

Representing Maritime Hospital Service Association: Dr. J. A. MacDougall, Saint John, chairman MHSA; W. R. Fiske, Moncton.

Representing Maritime Hospital Aids Association: Mrs. Gordon Leitch, president, Charlottetown.

Representing Maritime Hospital Exhibitors' Association: C. W. Carpenter, Moncton, N.B.

Representing Registered Nurses' Associations: One representative to be appointed by each association in Atlantic provinces. Member representing Registered Nurses' Association of Newfoundland is this year's voting member.—*Reported by W. Douglas Piercey, M.D.*

Alberta Leads in Hospital Beds

The Dominion Bureau of Statistics annual report on hospitals pointed out that Canada had a ratio of 4.75 beds per 1,000 of the population in 1953. Bed capacity reached a high of 151,000 at the end of that year. Leading the provinces with a ratio of 6.49 beds per 1,000 people was Alberta. Next were: Prince Edward Island, 5.97; Saskatchewan, 5.96; British Columbia, 5.75; Nova Scotia, 5.17; and Manitoba, 5.12. Provinces with less than the national average were Ontario, 4.59; Newfoundland, 4.51; New Brunswick, 4.10; and Quebec, 3.85.

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You will assure yourself of an adequate supply of clean, hot water and years of trouble-free service when you specify Whitlock-Darling Type "K" Storage Heaters. Fabricated in Monel, tougher and stronger than structural steel, they cannot rust and are highly resistant to corrosion. Don't be blinded by low, first-cost bargains that may turn into a never-ending rebuilding and replacement problem. Specify Darling Equipment and you get the results of over 66 years engineering experience plus craftmanship, performance and assured minimum maintenance costs. For complete information on *your* water requirements...write today and ask for bulletin 40M.

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This is a co-operative advertisement of
The International Nickel Company of Canada, Limited

DARLING

BROTHERS LIMITED
140 PRINCE ST., MONTREAL, CANADA

HALIFAX • SAINT JOHN • QUEBEC • ARVIDA • TIMMINS • OTTAWA
TORONTO • WINNIPEG • CALGARY • EDMONTON • VANCOUVER • ST. JOHN'S, NFLD.

Cours d'Extension en Comptabilité

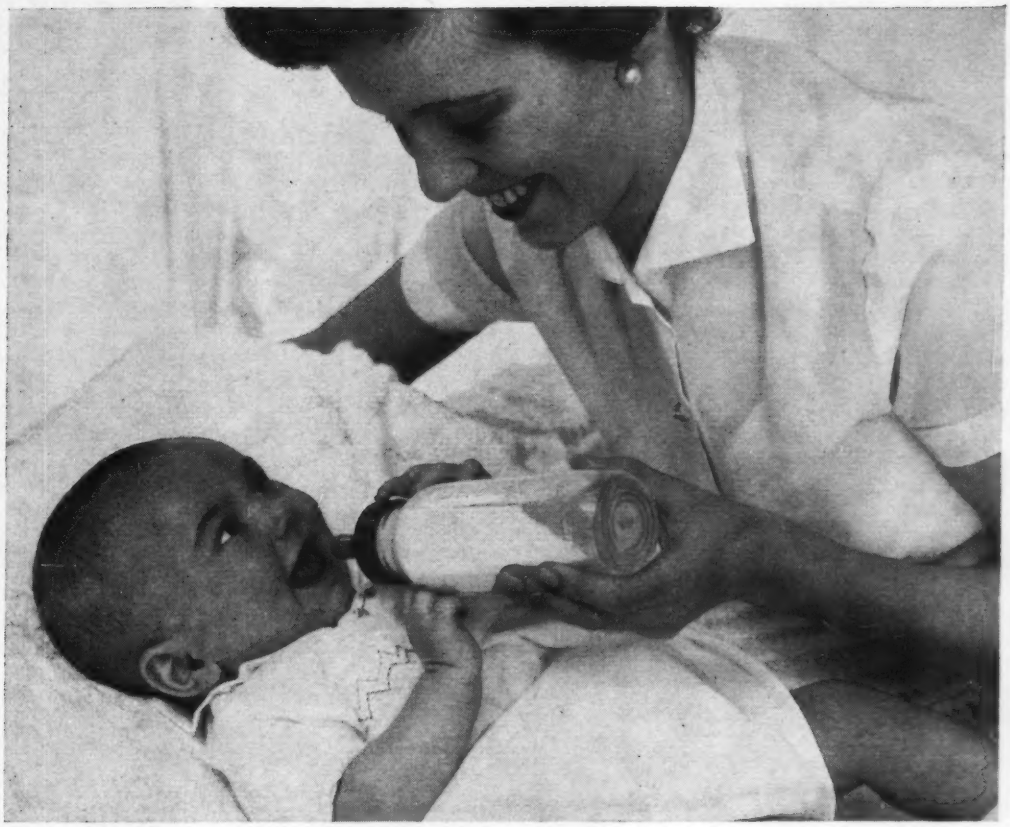
(Suite de la page 32)

édition tout en suivant de près la première apportera plus de clarté sur certains points. Le Comité de Comptabilité et de Statistiques a revisé les changements à faire et son rapport a été publié dans la revue *The Canadian Hospital*, juin 1955 page 42.

Un cours d'extension en comptabilité hospitalière a tout d'abord été préconisé par M. Walter W. B. Dick, président du Comité de Comptabilité et de Statistiques, lors de son adresse à la 12ième assemblée biennale de l'Association en 1953. L'assemblée avait alors soumis la question au Bureau des Gouverneurs et demandé au Comité d'Education de presenter un rapport sur ce sujet. Le Comité sur l'Education avait fortement recommandé ce projet. Cependant le Bureau des Gouverneurs a considéré qu'il était de son devoir d'assurer tout d'abord la continuité des deux cours déjà existants. C'est pourquoi en janvier dernier il a demandé à son Directeur Exécutif de préparer un rapport sur le financement de ces cours après le 31 août 1956, date à laquelle se terminent les octrois versés par la W. K. Kellogg Foundation. L'enquête a demonstré qu'en autant que le nombre des candidats demeurera le même, l'Association pourra à peu de frais maintenir ces cours jusqu'en 1960.

Rassuré, le Bureau des Gouverneurs a chargé son Directeur Exécutif de s'enquérir auprès des hôpitaux canadiens de l'opportunité du cours, du curriculum à suivre, et des moyens de le financer.

Un questionnaire sera bientôt préparé et envoyé aux diverses associations hospitalières leur demandant de le faire circuler parmi leurs membres.



A picture of satisfaction—and why not? This baby loves its Farmer's Wife, and mother knows that the formula milk recommended for her baby was prepared especially for infant feeding and infant feeding alone.

Farmer's Wife
FORMULA MILKS
COW AND GATE (CANADA) LIMITED, Brockville, Ontario

Evaporated Whole Milk

Concentrated Partly Skimmed Milk

Concentrated Skimmed Milk

"Specialists in the processing of milk foods for infant feeding"

The World on Your Door-Step

(The following editorial appeared in the "News Bulletin" of the International Hospital Federation, March, 1955.)

It would not be surprising if future generations came to regard the mania for holding conferences as one of the chief characteristics of the present age. A formidable number of international gatherings — congresses, conferences, seminars, study tours, working parties, to quote but a few of their titles—take place each year and are attended by an even more formidable number of participants from a variety of countries. In relation to the total number of workers employed in any given field, however, these participants are but the chosen few. What of the vast majority, those who are unable to travel; who do not have the opportunity of learning something, through personal contacts and discussions, both formal and informal, of the world about them and of the methods used by their colleagues abroad to solve problems which they themselves have to face daily? How many of them make good this deficiency by reading conference reports and professional journals from other countries? How many of them say that they are too busy to waste time reading, not realizing that the new ideas and suggestions to be found in such publications would in actual fact often lighten their burden by indicating means of simplifying their work and increasing efficiency?

A conference report is, first and foremost, a digest of the opinions and experiences of experts who have come together to study a given problem, or series of problems, of direct professional interest, and to pool their knowledge for their mutual benefit. Even the reader who has not been present at the meetings may share this knowledge and may derive inspiration and encouragement from an account of the views and activities of his colleagues. Perhaps they have nothing new to offer him; but he will at least feel that he is a member of a wider professional community and not an isolated individual left to his own devices.

Professional journals perform a similar function. The hospital journals which are published in a large number of countries serve as a link, not only between the hospital workers of the country concerned but between those of all countries which take an interest in professional activities abroad. Articles are contributed on hospital problems of all kinds; some are of particular relevance in the country of publication, while many others apply equally to hospitals all over the world. The reader of such journals has his own part to play; it may well be that he himself has acquired knowledge which would enable him to make a useful contribution to the solution of the problems about which he reads. He can pass on this information and render a valuable service, not only to his colleagues in other countries, but also to those whom they serve—their fellow-men.

The most unhappy of all men is he who believes himself to be so.

Physiological Monitor

Working under the sponsorship of the Veterans Administration (U.S.A.), the National Bureau of Standards has developed an electronic instrument, known as the NBS Physiological Monitor, which automatically detects changes in the physiological condition of a patient under anaesthesia throughout the course of an operation. This instrument measures the changes in the patient's blood pressure, heart beat, and respiration as they occur and presents the data on a panel for interpretation by the surgeon or anaesthiologist. A permanent record of the patient's condition during the operation is also provided by a recording device incorporated in the assembly.

Safety Features

The common use of explosive gas mixtures for anaesthesia makes it necessary that potential ignition sources be supplied with safeguards to prevent the occurence or propagation of explosions. Electrical equipment of the type required in the operating room console of the Monitor contains voltage sources, contractors, motors, and numerous hot filaments, all of which could serve as sources of ignition under certain conditions.

Equally important as ignition sources are possible static charge accumulations on the surfaces of the equipment and the accidental connection of the instrument housing or any of its parts to the power line through insulation failure.

To prevent the accumulation of electrostatic charges, the operating room console is equipped with conductive rubber casters grounded to the metal frame. However, the use of explosion-proof fixtures, as in fixed electrical installations for power line equipment, did not appear feasible for portable equipment of this size.

Instead a system based on the maintenance of a small positive pressure within the enclosure was designed. This made it unnecessary to seal the enclosure hermetically, although reasonable care was taken to keep the leakage small by restricting the size of openings. Thus, for example, the instrument panel is covered with a sheet of safety glass and sealed to the instrument case by means of a rubber gasket and compression frame.

A sliding vane compressor in the recorder console maintains the interior of the operating room console at about one-half pound pressure above that of the outside. Noise is eliminated by an acoustic filter located in the inlet side of the compressor. The output air of the compressor is first cooled by passage through a heat exchanger before it is delivered to the operating room console.

Safeguards are provided, which prevent the application of any power to the unit in the operating room unless the purging pressure is present. Also, a time delay inserted in the power line ensures that the purging system must be in operation for about two minutes before power can be applied to the unit.

To ensure the safety of the patient against possible short circuits or other accidental sources of electrical hazard, the electrodes used in measuring heartbeats are designed so that high-ohm resistors can be placed in each of them. Safety provisions have also been incorporated in the blood pressure measurement device to guard against the application of excessive pressure to the arm of the patient, or what is worse, the maintenance of an occluding pressure for long periods.

Excessive pressures are prevented by a mechanical pop-off valve which opens and relieves arm-band pressure when the system pressure exceeds a pre-set level. In addition, an adjustable electrical limit which is set to cause depression of the arm-band whenever the system pressure exceeds a value reasonably well above the patient's systolic pressure. In the event of power failure, air is discharged from the system by a solenoid-operated exhaust valve, which normally functions to discharge the system at the end of each blood pressure determination. — *National Bureau of Standards, Summary Technical Report.*

Honour to Discoverer of Anti-Leprosy Vaccine

The discoverer of a vaccine now showing promising results against leprosy was honoured when Sister Marie Suzanne of France was presented with the third annual award of the Damien Dutton Society, an international organization for aiding lepers. The vaccine is manufactured in Lyons, France, and shipped to 40 leprosariums throughout the world.

Provincial Notes

(Concluded from page 76)

work, which would take 2,000 employees three days to complete, in an hour and a half.

Nova Scotia

PICTOU. Capital and operating expenses at the Sutherland Memorial Hospital last year were largely responsible for the deficit of $7,791.90 reported at the annual meeting of the hospital board. The treasurer recommended, and was given authority to decide, that consideration be given to transferring funds from special accounts to the operating account.

* * * *

MIDDLETON. The Soldier's Memorial Hospital is to receive a $1,000 gas and oxygen machine for its operating room. This is part of the hospital equipment project of the Rosemary chapter of IODE. ●

Alberta Hospitals Convene

(Concluded from page 57)

the time of such treatment being given shall upon demand repay the actual expenses incurred by the first mentioned local authority" and

WHEREAS it is desirable that the responsibility of the local authority for the hospital care of the indigent sick transient should be obligatory and not permissive,

NOW THEREFORE BE IT RESOLVED that the Directors be requested to seek an amendment to the said sub-section (2) by which the word "shall" shall be substituted for the word "may".

New Officers

Hon. President: Hon. W. W. Cross, M.D., Minister of Health for Alberta.

Hon. Vice-president: Dr. D. R. Easton, Edmonton.

President: William Chessor, Lacombe.

Vice-president: S. V. Pryce, Calgary.

Secretary-treasurer: L. R. Adshead, Edmonton.

Board of Directors: Rev. Sister M. Immaculata, Lethbridge; Rev. Sister B. Knopic, Edson; Noreen Flanagan, Medicine Hat; H. P. Wright, Calgary; W. Crook, Brooks; Joseph Cramer, Drumheller; Leonard MacArthur, Peace River.

Chairman of the Economics Committee: Garnet Hollingshead, Edmonton. *—reported by Jane McNally*

Keep to the Center

Although the usual practice of keeping to the right is good and should be adhered to when using stairs, this is not the safest procedure when proceeding along a building corridor. There is always the possibility of accidental collision with persons emerging through door openings into the corridor and at intersecting corridors or blind corners. This is particularly hazardous in a hospital building where persons are frequently carrying articles, moving wheeled equipment, helping move a patient, or the patients themselves. It is always a good practice to go "around a corner" instead of turning, *i.e.*, moving to the center when approaching an interesection, especially if carrying articles or moving equipment.—*"Safety News Letter", April, 1955.*

The Nature of Learning

Those in charge of the actual instruction of employees need some understanding of the nature of learning and the means by which it can be made easier. Learning is a natural process for the normal person; it consists essentially of acquiring habits, good or bad.

Instruction may be defined as the act of helping the employee to acquire the specific desirable habits necessary for the performance of his task. The function of the instructor is to speed up the acquisition of the necessary habits and to bring about desirable modification of any bad habits.

Habits result from practice, from repetitive "doing". Desirable habits result only from the practice of the correct procedure. The learner must start with the correct method and practise it without deviation until he has formed a strong habit. It is the instructor's job to see that the learner's first and subsequent practice methods are all correct and to prevent any departure from the accepted procedure during the learning period.

Before he can start practising, the learner must have a clear mental picture of what he is to try to accomplish. Otherwise he will waste time in trial and error and partially learn some bad habits which must then be overcome. Therefore, whoever is responsible for instructing must be able to get across to the learner a clear understanding of what he is expected to do and precisely how he is supposed to do it. This is usually best accomplished by a combination of telling and showing.

The new billing clerk, for example, must be told and shown just how and where to get the data, how to operate the billing machine and what to do with the finished forms. She should be shown how the work is done, step by step, each step being explained and demonstrated fully. She may also be questioned to check her understanding before she actually tries to do the job.

Individuals will learn if given a chance and the more they are helped the faster they learn. If possible the learner should always receive instruction in the actual area where the work will be done.

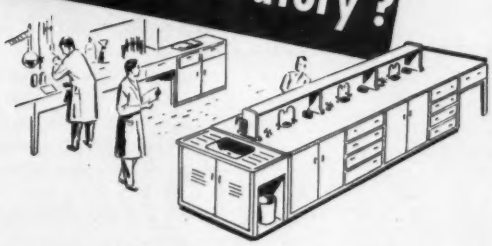
In teaching, the instructor must present an accurate pattern for the learner to follow. He cannot build up such a pattern unless he has analyzed the task and broken it down into its component elements. It is sometimes difficult for a skilled individual to analyze a job which he can do almost automatically. His own habits have become so strong that he acts with little conscious effort. He does not realize how much is involved, how many things he does, and how many judgments he makes in doing what appears to him a simple task. Hence it is essential that the instructor make a careful analysis of every task he teaches in order to identify all the points that must be called to the learner's attention. Without such a survey he will not be able to develop a complete pattern for the learner to follow.

—From a digest in "Institutions Magazine", March, 1955, of the bulletin "Minimizing the Cost of Breaking in New Personnel" by H. S. Hall of the University of Illino's. Published by the U.S. Department of Commerce.

Planning a NEW LABORATORY?

Let our representative sit in with you at your *earliest* planning session. Early consultation with an experienced laboratory expert regarding layout, equipment, connections, lighting and entry pay off well in satisfaction and economy. Costly future alteration can be avoided. There is no cost or obligation in using this service.

ADDING to your present laboratory?



Art Woodwork Limited and B. K. Johl Inc. are manufacturers and suppliers of a wide range of laboratory furniture—in wood or metal—including fume hoods, cabinets, counters, tables and service islands plus all the necessary fittings, fixtures and hardware.

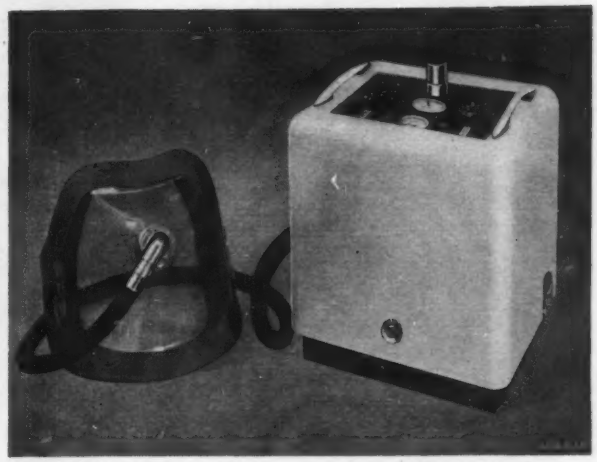
A catalogue will be mailed on request.

ART WOODWORK LIMITED *Furniture in* WOOD

B. K. JOHL INC. *Furniture in* METAL

894 Bloomfield Ave., Outremont, P.Q.

Ontario Associate: JAMES H. WILSON LIMITED
88 Adelaide Street West, Toronto, Ont.



. . . in the treatment of Poliomyelitis and cases with respiratory embarrassment . . .

the "SPIRASHELL"

CHEST-ABDOMEN RESPIRATOR

This respirator is the outcome of years of research into breathing machines by doctors who have designed the cuirass to fit both the normal or wasted patient and those with developing scoliosis. The shell covers the maximum area of trunk, is remarkably light in weight, and is designed to encourage lateral movement of the ribs and movement of the diaphragm, with a consequent near natural action of the lungs, thus enabling a lower operating pressure to be used within the cuirass.

The compact mobile electrically-driven pump has an infinitely variable speed control between 10 and 35 respirations per minute.

The hand operation for emergency is extremely simple.

For full details on this and other British surgical equipment and instruments, please write to:

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2719 YONGE STREET, TORONTO

sole distributors in Canada for, and subsidiary of

THE MEDICAL SUPPLY ASSOCIATION LTD.
LONDON, ENGLAND

For Sale

One pressure washer sterilizer (American Sterilizer Co.). Type TW11. Never been used. For full information write Box 732M, The Canadian Hospital, 57 Bloor St. W., Toronto.

Hospital Superintendent Wanted

For the Winchester and District Memorial Hospital. Fully modern and equipped 34 bed hospital, located in a friendly town, 32 miles south of Ottawa. Excellent meals, laundry processed. Live out. Duties to commence August 1st, 1955. Please state age, qualifications and experience, salary expected and furnish references. Apply, F. Erle Helmer, Winchester, Ont.

X-Ray Equipment For Sale

X-RAY, Heavy Duty Table, General Electric 200-M.A. — Model No. 39, Serial No. 201674, with Head, Tubes, 2 Fluoroscopic Screens and 2 cones, less transformer and control unit.

Changer, Cassette, Floor Mounted Type, Horizontal Picker Style No. 1453. Crown Equipment Co. Limited, 1011 Bleury St., Montreal, Quebec.

Director of Nursing Wanted

Applications are being received for the position of Director of Nursing: Hospital capacity 275 beds, 26 bassinettes. This position would include overall supervision of nursing and nursing education; School of Nursing of 53 students.

Applications should be addressed to the Administrator, General Hospital of Port Arthur, Port Arthur, Ont. stating qualifications, experience, and salary requirements.

DO YOU NEED

an administrator
an assistant administrator
registered female or male nurse (English)
registered Practical nurses (English)
registered Mental nurse (English)
stenographers
aids, domestics
executive housekeeper for 240-bed hospital
female registered Pharmacist wanted for an Ohio hospital

No fee to employer

International Employment Agency, 504 Victoria Ave., Windsor, Ont.

POSITIONS OPEN

School of Nursing, in modern Northern Ontario Hospital, has the following positions open for September, 1955:

Clinical Teachers for Psychiatry and Medical-Surgical Nursing; Instructor in Nursing Arts; Instructor in Science. References required. Some experience preferred.

Gross salary $255.00 to $265.00 per month.

Write to Box 624S
The Canadian Hospital,
57 Bloor St. West,
Toronto, Ontario.

Staff Wanted
SUDBURY MEMORIAL HOSPITAL

An entirely new 300-bed General hospital to be opened this Fall requires, immediately, qualified staff for the following positions:

- Associate director of nursing service
- Administrative assistant (in-service education)
- Operating room supervisor
- Obstetrical supervisor
- Central supply supervisor

For further information write to the Director of Nursing Service, Sudbury Memorial Hospital, 468 Ramsey Rd., Sudbury.

Dietitian Required

For 100-bed hospital. Apply to Superintendent of Charlotte County Hospital, St. Stephen, N.B.

Operating Room Supervisor Wanted

Qualified by experience or Post-graduate training to commence duty July or August in preparation to taking charge of operating room late in the Fall. For full particulars please apply to Director of Nurses, Swift Current Union Hospital, Swift Current, Saskatchewan.

Position as Assistant Medical Superintendent Wanted

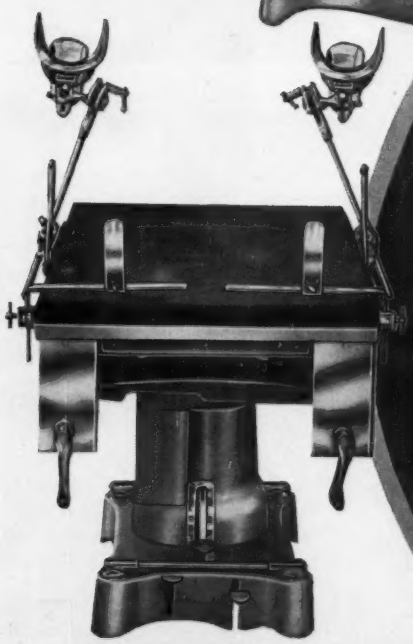
Graduate Doctor of Medicine, Kaunas, Lithuania. Practised medicine in Vienna for 7 years, including resident physician in Wagner-Gordon Hospital. Municipal physician for one year. House doctor for 5 years in well known Toronto clinic. 2 years as medical interne in Canadian hospitals. Age 38, married, Canadian citizen. Desires position as Assistant Medical Superintendent, anywhere in Canada. Box 718V, The Canadian Hospital, 57 Bloor St. W., Toronto.

Better Living Threatens Water

The higher the standard of living, the greater the danger of pollution. Improved hygiene means the rapid removal of dirt and waste, which leads to pollution. Greater material wealth must mean an increase in manufacture, which leads to pollution. Less drudgery means a greater use of machines, which particularly through the processing of foods leads to pollution. The more we have advanced the more waste we have produced, and to expect our lakes and rivers to cope with the mess as they were often able to do in the past is today asking too much.—*from "World Health Today", April 7, 1955.*

For Speed and Efficiency...
For Simplified O. B. Procedure

SHAMPAINE
HAMPTON
O. B. TABLE



The Shampaine Hampton offers superior advantages for the physician, nurse, all persons involved in O.B. procedure.

* **NEW CRUTCH SOCKET**
  Permits easy, rapid crutch adjustment — lateral, radial and vertical — with one lever. Saves time and labor.

* **HEAD-END CONTROLS**
  All controls conveniently located at head-end for speed and efficiency.

* One crank changes table from labor position to delivery position.
* Leg section telescopes from fixed body to full length.
* For close-up work, top can be rotated without moving base.
* Easy to clean; working parts are completely concealed, and panels are stainless steel.

Shampaine COMPANY

MANUFACTURERS OF A COMPLETE LINE OF PHYSICIANS' AND HOSPITAL EQUIPMENT

SHAMPAINE COMPANY, Dept. CH5-7,
1920 South Jefferson Ave., St. Louis 4, Mo.

Please send information on the Shampaine Hampton O.B. Table.

My dealer is .....

Name .....

Address .....

City ..... Zone ..... Prov. .....

News Released by Hospital Supply Houses

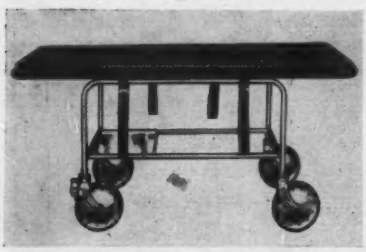
By C.A.E.

Hausted Wheel Stretcher

The Stevens Companies have announced the introduction of a new budget "Hausted Economy" model 1,000 wheel stretcher. This new stretcher is of sturdy welded tubular construction in either attractive silver lustre finish or stainless steel.

The litter top is a full 26¾" x74" and can be completely removed in a minute. It is slotted for holding straps to prevent pad slide and is surrounded by a heavy duty rubber bumper.

All four 10" casters on the stretcher have adjustable cup and cone ball bearings with ball bearing swivel joints. An aluminum blanket shelf is an integral part of the lower box frame.



Optional equipment includes a one-inch foam rubber pad with three attached holding straps; lock and brake casters; adjustable restraining straps; a conductive rubber pad; and conductive rubber tires. For further information write any branch of the Stevens Companies.

Polyethylene Tubing In Sterile Form

Polyethylene tubing is now being manufactured and distributed under the "Intramedic" trade mark, by Clay-Adams, Inc. in sterile form. Packaged in tough polyethylene envelopes, the tubing is ready for immediate use as soon as the package is opened. It is available in the following sizes: PE-50/536 (36" length), PE-90/S12 (12" length), PE-190/S12 and PE-200/S12. Some of the more important uses for these sizes are intravenous therapy, caudal and spinal analgesia, exchange transfusions in the newborn, and tube feeding for prematures.

The new tubing is electron sterilized in the package. It is passed under special high voltage generators where streams of electrons bombard the tubing, making it sterile and pyrogen free. Electron sterilization kills all spores, spore formers and all bacteria. Random sampling and culture tests are performed to assure that every package shipped is sterile. The polyethylene tubing is also animal tested to guarantee freedom from trace irritants that could cause tissue reaction.

New Canadian Hoffman Plant

The Canadian Hoffman Machinery Company, Limited, a subsidiary of the U.S. Hoffman Machinery Corporation, announces that production of laundry, dry cleaning, and pressing machines has been transferred to a larger plant in Fergus, Ontario.

Mr. Hyman Marcus, president of the parent company, said the new plant is designed to increase production, reduce costs and pave the way for the addition of new products. He added that the move will put the Canadian subsidiary in a position to parallel the progress which the parent company has achieved in the United States during the past year.

Canadian Hoffman sales, accounting, and engineering headquarters will be transferred to its offices at 126 Dundas Street West, Toronto.

New Hot'N Cold Water Cooler

An innovation in water coolers, the Oasis Hot'N Cold Cooler has just been introduced across Canada by G. H. Wood & Co. Limited. By pressing a button it is possible to obtain piping hot water to make instant coffee, tea, cocoa, or even soup. By pressing another button, cool, refreshing drinking water is obtained.

The coolers come in two models, the bottle type which merely plugs into any electrical outlet and the pressure type which is hooked up to the water system.

Both models provide up to 60 cups of 185° hot water every hour and at the same time an unlimited amount of cold drinking water. The coolers are guaranteed for five years. For literature write to: G. H. Wood & Co. Limited, Box 34, Toronto 14, or to any of their branches across Canada.

Combination Y-Set and Blood Pump

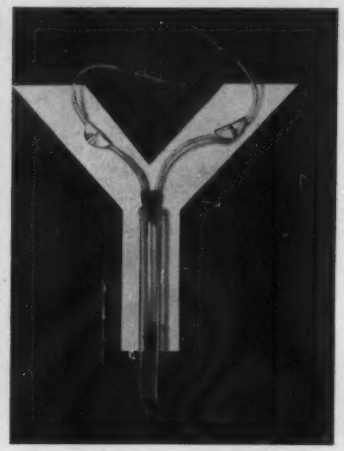
A new, flexible housing combination Y-Set and blood pump for the simultaneous or alternate administration of

(Concluded on page 104)

Across the Desk

(Concluded from page 102)

parenteral solutions and blood has been announced by Baxter Laboratories of Canada Limited, Acton, Ontario.



The combination plexitron R49 set adds the advantage of being able to give blood safely under pressure to the merits of the Y-hookup. The pump is located directly below the junction of the Y. Pressure administration is possible only when the pump housing is full. When the fluid level in the pump drops the unique ball valve also drops, thus automatically discontinuing pressure administration. This safety feature prevents the set from pumping air. The operator can return to normal administration at any time in a matter of seconds. Fluids may be administered by closing the clamp on the arm of the Y leading to the blood bottle and opening the clamp on the arm leading to the solution bottle.

For further information write to Ingram & Bell Limited, Toronto, distributors of Baxter products.

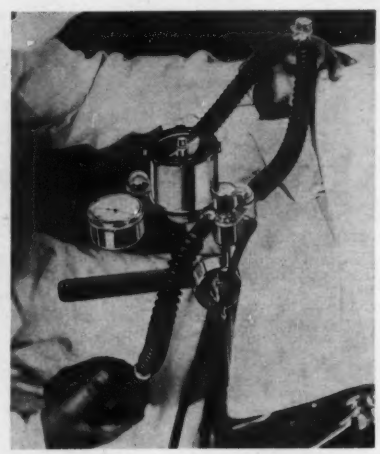
Ohio Infant Circle Absorber

The full advantages of the circle absorption system are made available for use in paediatric anaesthesia with the new Ohio Chemical No. 60 Infant Circle Absorber, through Ohio Chemical Canada Limited, Toronto.

For physiological reasons, adult size circle absorbers are unsuited for use with infants. The Ohio Chemical unit is designed specifically for infant use. Among its major advantages are quicker control of anaesthetic mixture, elimination of dead space in the "Y" piece, reduction of CO_2 diffusion, minimum resistance, and flexible positioning.

The unit has an adjustable pressure relief valve, a new, lightweight directional valve, and a bag pressure manometer. A pair of interchangeable soda-sorb cannisters is provided with the unit. Cannisters are attached with a simple clamp screw which simultaneously secures the transparent cover and seals the cannister to the body of the absorber. The exchange of cannisters can be effected by one hand in less than 30 seconds without interuption of the anaesthetic or loss of the contents of the circuit to atmosphere. Any machine equipped to deliver oxygen, anaesthetic gases, and ether vapour may be used with the No. 60 absorber.

The unit is supplied with a "Y" piece for intratracheal work which fits Adams type connectors. Rovenstine type connectors may be accommodated through the use of an optional "Y" piece.



Complete information on the Ohio Chemical No. 60 Infant Circle Absorber may be obtained by writing the company for Form No. 4650.

Abbott Builds Stock Depot in Toronto

Abbott Laboratories, Limited, pharmaceutical manufacturers, are to build a large stock depot and sales headquarters for Ontario, in Toronto. Two and a half acres of land in the Don Mills development have been acquired for this purpose. The building to be erected thereon will provide fifteen thousand square feet of floor space.

The new Abbott branch will probably be ready for operation in the Spring of 1956.

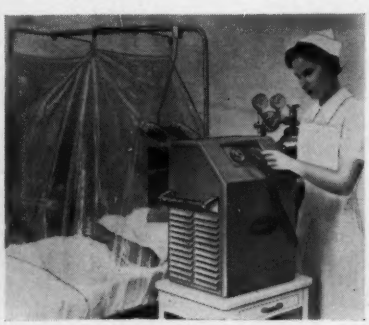
O. E. M. Announces Portable Iceless Oxygen Tent

The O.E.M. Corporation, East Norwalk, Connecticut, recently introduced the O. E. M. Mechanette, a brand new portable, iceless oxygen tent. Equally advantageous for small or large hospitals, it is a compact, lightweight spacesaver. It can be hung on a crib or a bed headboard by means of the accessory bed hangers, thus keeping ward aisles clear and uncluttered.

One of the many features of the revolutionary O. E. M. Mechanette is the exclusive automatic separate air-conditioning. Should the oxygen flow fall below 6 liters per minute or fail for any reason, a valve opens automatically to draw in room air, and therefore prevents any possibility of CO_2 build-up under the canopy. In addition, this feature permits the Mechanette to be used as an air-conditioning unit with air only. A rapid build-up to 60% oxygen concentration under the canopy is possible because leaks are prevented by one-piece cast aluminum internal ducts, puncture-proof plastic external ducts and neoprene seals.

The temperature control has a built-in modulation effect that provides cooling at high temperatures without chilling at low temperatures.

The outer fire-resistant cabinet of the Mechanette is constructed of the same rugged, light-weight boltaron plastic that is being used in the latest jet aircraft and will not dent, scratch or crack. The one-piece front and top of the Mechanette is easily removed to permit quick accessibility, cleaning, and maintenance of all parts. The sealed compressor unit operates silently on 115 volt 60 cycle A.C. and is rated at 1250 B.T.U.



Index of Advertisers

JULY, 1955

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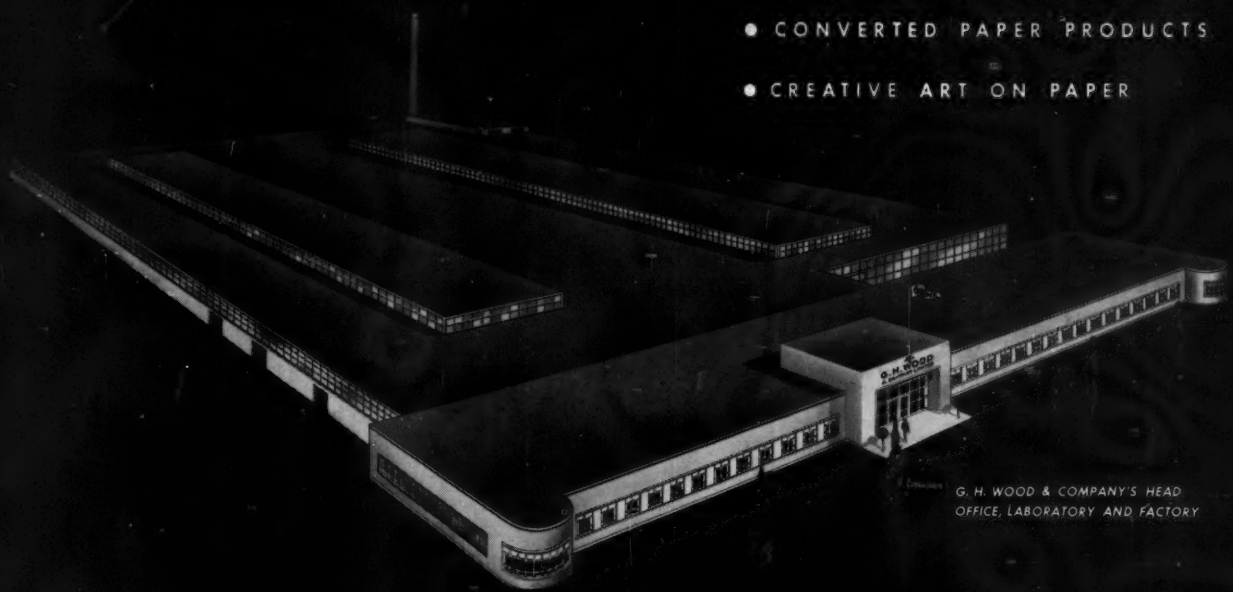

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